Rocky Mountain Medical Journal

July
1954

Vol. 51—No. 7
35c Per Copy
$3.00 Per Year

DECREASED PAIN SENSITIVITY AND ITS DANGERS
HOUSEWIVES' ECZEMA—PROGRAMS TO REDUCE NEONATAL MORTALITY—SKIN SUNLIGHT AND CANCER
SANDPAPER ABRASION TREATMENT OF FACIAL SCARS—TOLSEROL IN THE POST-ALCOHOLIC SYNDROME
WYOMING AND NEW MEXICO PRESIDENTIAL ADDRESSES—TUMORS OF THE THYROID GLAND
STATISTICAL SURVEY OF CASES OF PULMONARY EMBOLISM—SURGICAL MANAGEMENT OF CHOLECYSTIC DISEASE

BENADRYL®

Patients troubled by lacrimation, nasal discharge, and sneezing respond to BENADRYL and enjoy symptom-free days and restful nights.

MEDICAMENTA VERA · P-D Co.

Parke, Davis + Company

DETROIT, MICHIGAN

Table of Contents

VOLUME 51 NUMBER 7

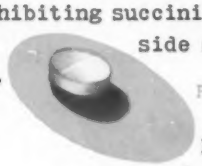
JULY, 1954

NEOHYDRIN®

BRAND OF CHLORMERODRIN

NORMAL OUTPUT OF SODIUM AND WATER

Individualized daily dosage of NEOHYDRIN -- 1 to 6 tablets a day as needed -- prevents the recurrent daily sodium and water reaccumulation which may occur with single-dose diuretics. Arbitrary limitation of dosage or rest periods to forestall refractivity are unnecessary. Therapy with NEOHYDRIN need never be interrupted or delayed for therapeutic reasons. Because it curbs sodium retention by inhibiting succinic dehydrogenase in the kidney only, NEOHYDRIN does not cause side actions due to widespread enzyme inhibition in other organs.



Prescribe NEOHYDRIN in bottles of 50 tablets. There are 18.3 mg. of 3-chloromercuri-2-methoxypropylurea in each tablet.

Leadership in diuretic research

LAKESIDE LABORATORIES, INC. · MILWAUKEE 1, WISCONSIN

ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered, U. S. Patent Office

Publication Office:
835 Republic Building (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 2-0547

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, the Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

Advertising: National representatives: The State Journal Advertising Bureau, 535 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

Subscription: $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second Class Matter: Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

To ease the blow when you say..."No Salt!"....

— gives a zestful "salty" flavor to the sodium-restricted diet — helps to keep the patient on the salt-free regimen by making meals tasty.

Neocurtasal may be used wherever sodium restriction is indicated — it is completely sodium-free. May be used like ordinary table salt — added to foods during or before cooking or used to season foods at the table.

WINTHROP

Neocurtasal

"...trustworthy non-sodium containing salt substitute"[1]

supplied in 2 oz. shakers and 8 oz. bottles.

Write for pad of diet sheets.

1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

WINTHROP-STEARNS INC.

Neocurtasal, trademark reg. U.S. & Canada

NEW YORK 18, N.Y. • WINDSOR, ONT.

THE COLORADO STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: BROADMOOR HOTEL, COLORADO SPRINGS, SEPT. 21-24, 1954

OFFICERS

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1954 Annual Session.

President: Claude D. Bonham, Denver.

President-Elect: Samuel P. Newman, Denver.

Vice President: Lawrence D. Buchanan, Wray.

Constitutional Secretary (three years): Irvin E. Hendryson, Denver, 1954.

Treasurer (three years): Frank I. Nicks, Colorado Springs, 1956.

Additional Trustees (three years): Robert T. Porter, Greeley, Vice Chairman, 1954; William R. Lipscomb, Denver, 1955; Thomas K. Mahan, Grand Junction, 1955; C. Walter Metz, Denver, 1956.

(The above nine officers compose the voting membership of the Board of Trustees. William A. Liggett, Denver, and Harry C. Bryan, Colorado Springs, immediate Past-Presidents, are ex-officio non-voting Trustees. Dr. Hendryson is Chairman of the Board and Dr. Porter is Vice Chairman for the 1953-54 year.)

Board of Councilors (three years): District No. 1: Paul R. Hildebrand, Brush, 1954; No. 2: Ella A. Mead, Greeley, 1954; No. 3: Osgoode S. Philpott, Denver, 1954; No. 4: Ward C. Fenton, Rocky Ford, 1956; No. 5: Scott A. Gale, Pueblo, 1956; No. 6: Herman W. Reth, Vice Chairman, Monte Vista, 1956; No. 7: Leo W. Lloyd, Chairman, Durango, 1955; No. 8: Harvey M. Tupper, Grand Junction, 1955; No. 9: Ray G. Witham, Craig, 1955.

Board of Supervisors (two years): J. Lawrence Campbell, Denver, 1954; W. S. Cleland, Delta, 1954; Harold E. Haymond, Greeley, 1954; Robert A. Hoover, Salida, 1954; William C. Service, Colorado Springs, 1954; J. Alan Shand, La Junta, 1954; David W. McCarty, Longmont, 1955; Duane F. Hartshorn, Fort Collins, 1955; Geno Saccomanno, Grand Junction, 1955; Kenneth H. Beebe, Sterling, 1955; V. V. Anderson, Del Norte, 1955; William N. Baker, Pueblo, 1955.

Delegates to American Medical Association (two years): William H. Halley, Denver, 1954; (Alternate: Kenneth C. Sawyer, Denver, 1954); George A. Unfug, Pueblo, 1955; (Alternate: E. H. Munro, Grand Junction, 1955).

Foundation Advocate: Walter W. King, Denver.

House of Delegates: Speaker, Eugene B. Ley, Pueblo; Vice Speaker, John A. Weaver, Jr., Greeley.

Executive Office Staff: Mr. Harvey T. Sethman, Executive Secretary; Mrs. Geraldine A. Blackburn, Executive Assistant; 835 Republic Building, Denver 2, Colo.; Telephone: AComa 2-0547.

General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

STANDING COMMITTEES

Committee on Constitution, By-Laws and Credentials: James M. Perkins, Chairman, Denver; George Balderston, Montrose; Lawrence L. Hick, Delta; Frank H. Zimmerman, Pueblo; John L. McDonald, Colorado Springs; Eugene Wiege, Greeley; Roger G. Howlett, Golden.

Health Education (two years): Lewis Barbato, Denver, Chairman, 1955; Doris Benes, Haxtun, 1954; Archer C. Sudan, Grand Junction, 1954; Miss Norma Johannis, Denver, 1954; Donn J. Barber, Greeley, 1954; Richard W. Whitehead, Denver, 1955; William C. Beaver, Grand Junction, 1955; R. Sherwin Johnston, Jr., La Junta, 1955, and Dwight C. Dawson, Canon City, 1955.

Sub-Committee on School Health: Lewis Barbato, Denver, Chairman; Mary L. Moore, Grand Junction; William C. Service, Colorado Springs; W. Lloyd Wright, Golden; Victor E. Cram, Fort Collins; Mariana Gardner, John A. Lichty and Leland M. Corliss, all of Denver.

Library and Medical Literature: Lorenz W. Frank, Chairman, Denver; T. M. Rogers, Sterling; A. J. Helm, Greeley; Nolie Mumey, W. G. Davis, William B. Condon, Glenn T. Foust, Jr., and George D. Wilcox, all of Denver.

Medical Education and Hospitals: William C. Black, Chairman, Denver; Harry H. Lamberson, Colorado Springs; N. L. Beebe, Fort Collins; Kenneth E. Prescott, Grand Junction; Archibald R. Buchanan, Robert S. Liggett, Frank B. McGlone, and Charley J. Smyth, all of Denver.

Medical Service: Fredrick H. Good, Chairman, Denver, 1954; Eugene B. Ley, Pueblo, 1954; Geno Saccomanno, Grand Junction, 1955; Robert K. Brown, 1955, Roy L. Cleere, 1955, Harry C. Hughes, 1954, McKinnie L. Phelps, 1954, and Kenneth C. Sawyer, 1955, all of Denver.

Medical Service Subcommittees:

Distribution of Physicians: Eugene B. Ley, Pueblo, Chairman; Autrey Croke, Colorado Springs; Warren Gillette, Boulder; L. S. Sampson, Las Animas; William T. Boehm, Henry A. Buchtel and John M. Nelson, all of Denver.

Prepayment Services: Harry C. Hughes, Denver, Chairman; J. W. McMullen, Colorado Springs; George E. Garrison, Fort Collins; Robert S. Henderson, Longmont; Raymond A. Nethery, Pueblo; James R. Blair, Jr., Charles G. Freed, Terry J. Gromer, Gilbert R. Hall and Whitney C. Porter, all of Denver.

Indigent Medical Services: McKinnie L. Phelps, Denver, Chairman; Paul A. Draper, Colorado Springs; Everett H. Munro, Grand Junction; George R. Buck and William A. Liggett, Denver.

Medical Care of Veterans: Executive Committee: Robert K. Brown, Denver, Chairman; Frank B. McGlone, Denver, and William B. Condon, Denver. **Additional Members:** Jackson L. Sadler, Fort Collins; William N. Baker, Pueblo; Harvey M. Tupper, Grand Junction; William A. Campbell, Colorado Springs.

Blood Banks: Geno Saccomanno, Grand Junction, Chairman; William A. Rettberg, Vice Chairman, Denver; David R. Akers, Denver; Winthrop B. Crouch, Colorado Springs; and A. J. Miller, Pueblo.

Hospital-Professional Relations: Kenneth C. Sawyer, Denver, Chairman; Adalbert Miskowiec, Center; Everett H. Munro, Grand Junction; Joseph A. Leonard, Lakewood; John A. Weaver, Greeley; George E. Wright, Longmont; Douglas R. Collier, Wheatridge; William M. Ivers, John T. Jacobs, Thomas J. Kennedy, Roderick J. McDonald, Louis A. Pollock, Wendell P. Stampfli, George Wolfgast, all of Denver.

Emergency Medical Service: Roy L. Cleere, Denver, Chairman; F. H. Longwell, Denver, Vice Chairman; Kenneth E. Gloss, Colorado Springs; William H. Jackson, Fort Morgan; John W. McDonald, Sterling; L. W. Holden, Boulder; Rudolph E. Giehm, Harry C. Hughes, K. A. Jankovsky, Roderick J. McDonald, Foster Matchett, Marshall G. Nims, Mordant E. Peck, Myron B. Pedigo, Thad P. Sears, Karl F. Sunderland, David L. Wahl, and Arthur R. Woodburne, all of Denver.

Intra-professional Insurance Problems: Ervin A. Hinds, Denver; Robert T. Porter, Greeley; George L. Pattee, Chairman, Marvin E. Johnson, Kester V. Maul, Willis L. Bennett, Bennett W. Muir, E. Stewart Taylor, Mr. J. P. Nordlund, all of Denver.

Liaison Committee With Nurses Organizations: Harold D. Palmer, Chairman; Walter E. Vest, Francis Manlove, Mr. DeMoss Taliaferro, Mr. John E. Lawson, all of Denver.

Medicolegal: (two years): William W. Haggart, Denver, Chairman, 1954; Rudolph W. Arndt, 1954; Hamilton I. Barnard, 1955; Charles S. Bluemel, 1955; Edward J. Meister, 1954; Ralph H. Verploeg, 1955, all of Denver.

Necrology: Frances McConnell-Mills, Denver, Chairman; Roger S. Whitney, Colorado Springs.

Public Health: John I. Zarit, Denver, 1954, Chairman; George A. Unfug, Pueblo, 1954; James S. Cullyford, 1954, William A. Dorsey, 1954, Monroe R. Tyler, 1954, Vernon K. Anderl, 1955, E. L. Binkley, Jr., 1955, Frank C. Campbell, 1955, Edward S. Miller, 1955, Clyde E. Stanfield, 1955, all of Denver.

Public Health Subcommittees:

Cancer Control: Frank C. Campbell, Denver, Chairman; Walter M. Boyd, Greeley; Walter C. Herold, Colorado Springs; Sion W. Holley, Loveland; Stephen B. Phillips, Salida; C. L. Davis (D.V.M.), John B. Grow, N. Paul Isbell, Alexis E. Lubchenco, Harold D. Palmer and Mr. Hugh Terry, all of Denver. **Subcommittee on Cancer Conference:** Frederick H. Brandenburg, Denver, Chairman; Vernon K. Anderl, Frank C. Campbell, W. W. Haggart, Stanley K. Kurland, J. Leonard Swigert, and A. R. Woodburne, all of Denver.

Chronic Diseases: George A. Unfug, Pueblo, Chairman; Lloyd W. Anderson, Sterling; Roland A. Raso, Grand Junction; Nicholas S. Saliba, Walsenburg; David R. Barglow, Trinidad; Robert H. Smith, Colorado Springs; Miriam C. Benner, Richard C. Cullen and Edward J. Delehanty, all of Denver.

Crippled Children: E. L. Binkley, Jr., Denver, Chairman; Henry N. Russell, Jr., Greeley; Mary L. Moore, Grand Junction; R. H. Mellen, Colorado Springs; Sidney E. Blandford, H. Alexander Bradford and Fred H. Hartshorn, all of Denver.

Industrial Health: James S. Cullyford, Denver, Chairman; Joseph J. Parker, Grand Junction; Arthur W. Evans, Pueblo; Robert F. Bell, Lewis C. Benesh, Maurice D. Gaon, Joseph L. Glaser, George P. Lingenfelter, W. J. Longeway, Sherman S. Pinto, Donald G. Roberts, all of Denver.

Maternal and Child Health: Vernon K. Anderl, Denver, Chairman; W. R. Jacobson, Grand Junction; Mary H. Frantz, Montrose; Maurice E. Snyder, Colorado Springs; Donn J. Barber, Greeley; Garfield F. Hawlick, Pueblo; John H. Amesse, Paul D. Bruns, Lewis R. Day, Ruth B. Howard, Leo J. Flax R. L. Isberg and John D. Whitmore, all of Denver.

Mental Health: Clyde E. Stanfield, Denver, Chairman; F. H. Zimmerman, Pueblo; W. Y. Takahashi, Boulder; Paul A. Draper, Colorado Springs; Karl J. Waggener, Pueblo; William R. Conte, Greeley; Lewis Barbato, R. Robert Cohen, F. G. Ebaugh, John M. Lyon, Norbert L. Shere and Charles A. Rymer, all of Denver.

Rehabilitation: William A. Dorsey, Denver, Chairman; Max M. Leder, Denver; Kenneth W. Olshausen, Boulder; David Boyer, Pueblo; Martin E. Anderson, Jr., Hamilton I. Barnard, Robert F. Berris, Harold Dinken, Sidney H. Dressler, Bradford Murphey and Mr. Dorsey Richardson, all of Denver.

Rural Health: Monroe R. Tyler, Denver, Chairman; James H. White, Greeley; Mason M. Light, Gunnison; Ernest G. Cerlani, Kremmling; John G. Hedrick, Wray; F. A. Humphrey, Henry P. Thode, both of Fort Collins; Charles A. Cassidy, Monte Vista; Portia Lubchenco, Sterling; Hugh F. Williamson, Paonia; Albert T. Waski, Akron; V. E. Wohlauer, Brush; James M. Fraser, Grand Lake; Raymond T. Shima, Rocky Ford; Paul E. Tramp, Loveland; Norman A. Brethouwer, Montrose; Mr. Marvin Russell, Denver; Mrs. Tee Sims, Denver.

Sanitation: Edward S. Miller, Denver, Chairman; Harold Grabow, Canon City; Richard L. Davis, La Junta; Fritz Rosenberg, San Luis; C. Oliver Roberts, Boulder; Mr. Jean Breitenstein, E. N. Chapman, Bernard T. Daniels, Lloyd Florio, Mr. William Gahr, J. Burris Perrin, all of Denver.

Tuberculosis Control: John I. Zarit, Denver, Chairman; L. W. Holden, Boulder; Robert J. Groom, Grand Junction; A. M. Mullett, Colorado Springs; William F. Stone, Colorado Springs; H. M. Van Der Schouw, Wheatridge; W. Kemp Absher, Pueblo; H. H. Kerr, Pueblo; John A. Frantz, Montrose; W. J. Hinzelman, Greeley; T. K. Gleichman, Robert S. Liggett, W. S. Prenzlau, Arthur Robinson, Louis Rotenberg, all of Denver.

THE COLORADO STATE MEDICAL SOCIETY

Public Policy: G. C. Milligan, Englewood, Chairman; Karl F. Arndt, Denver, Vice Chairman; Paul A. Draper, Colorado Springs; Morgan A. Durham, Idaho Springs; Jackson L. Sadler, Fort Collins; Richard F. LaForce, Sterling; B. T. Daniels, Frank B. McGlone and J. Robert Spencer, all of Denver; Heman R. Bull, Grand Junction; Ward C. Fenton, Rocky Ford; William N. Baker, Pueblo; Ex-officio: Claude D. Bonham, Denver, President; Samuel P. Newman, Denver, President-Elect; Irvin E. Hendryson, Denver, Constitutional Secretary.

Public Policy Subcommittees:

Legislation: Cyrus W. Anderson, Denver, Chairman; John C. Lundgren, Julesburg; Harry C. Bryan, Colorado Springs; John B. Farley, Pueblo; George A. Unfug, Pueblo; James P. Rigg, Grand Junction; Hamilton I. Barnard, William A. Hines, Roderick J. McDonald, Bradford Murphey, Samuel P. Newman, McKinnie L. Phelps, and Kenneth Sawyer, all of Denver.

Publicity: William B Condon, Denver, Chairman; John S. Bouslog, Denver, Vice Chairman; Karl F. Arndt, George H. Curfman, Jr., Ira Dixson, Irvin E. Hendryson, Bradford Murphey, Raymond C. Scannell and Clyde E. Stanfield, all of Denver.

Weekly Health Column and Health Articles: Robert P. Harvey, Denver, Chairman; George H. Curfman, Jr., Frank C. Campbell, Charles B. Freed, Charles G. Gabelman, John G. Hemming, Jr., Joseph B. McCloskey, William A. Mayer, Jr., Aaron Paley, Donald K. Perkin, Seymour E. Wheelock, all of Denver.

Rocky Mountain Medical Conference: George P. Lingenfelter, Denver, 1957, Chairman; D. W. Macomber, 1954; Terry J. Gromer, 1955; William Covode, 1956; and L. Clark Hepp, 1958, all of Denver.

Scientific Program: William B. Coppinger, Denver, Chairman; Frederick H. Brandenburg, Denver, Vice Chairman; John W. Bradley, Colorado Springs; Kenneth W. Dumars, Jr., Colorado Springs; Edgar A. Elliff, Sterling; Vernell W. Curry, Pueblo; Willis L. Bennett, Samuel B. Childs, Felice A. Garcia, Chauncey A. Hager, Gordon Meiklejohn, E. Paul Sheridan and E. Stewart Taylor all of Denver.

Entertainment: William M. Covode, Denver, Chairman; Louis J. Kennedy, Colorado Springs; Craig W. Larimer, Colorado Springs; Mr. Edward B. Ghent, Denver.

SPECIAL COMMITTEES

Advisory to Auxiliary: Bernard T. Daniels, Denver, Chairman; William B. Lipscomb, Denver; Harry C. Bryan, Colorado Springs.

Advisory to U.M.W. Welfare Fund (three years): John S. Bouslog, Denver, 1954, Chairman; E. B. Ley, Pueblo, 1954; Mason M. Light, Gunnison, 1954; James M. Lamme, Sr., Walsenburg, 1955; Ligon Price, Mt. Harris, 1955; R. J. Ralston, Holyoke, 1955; Gilbert Balkin, Denver, 1956; Royal H. Finney, Pueblo, 1956; W. W. Haggart, Denver, 1956.

American Medical Education Foundation: James P. Rigg, Grand Junction, Chairman; James R. Kennedy, Colorado Springs; Robert T. Porter, Greeley; Lester L. Ward, Pueblo; J. Lawrence Campbell, Atha Thomas, Ervin A. Hinds and William A. Liggett, all of Denver.

Automotive Safety: Horace E. Campbell, Denver, Chairman; Freeman D. Fowler, Idaho Springs; Edward H. Vincent, Colorado Springs; William C. Beaver, Grand Junction; Harold H. Kerr, Pueblo; W. Y. Takahashi, Boulder; Woodrow E. Brown, Paonia; J. Gordon Hedrick, Wray; Martin G. Van Der Schouw, Fort Collins; T. M. Rogers, Sterling; Marx S. Donovan, Wray R. Gardner, George W. Holt, Homer G. McClintock, Karl F. Sunderland and Robert W. Viehe, all of Denver.

Blue Shield Fee Schedule Advisory Committee: Fred A. Humphrey, Fort Collins, Chairman; Lloyd W. Anderson, Sterling; John H. Amense, Robert F. Bell, George R. Buck, J. Lawrence Campbell, John G. Griffin, John B. Grow, Daniel R. Higbee, Harry C. Hughes, Frank B. McGlone, Douglas W. Macomber, Bradford Murphey, John M. Nelson, James A. Philpott, Kenneth Sawyer, Warren W. Tucker, John I. Zarit, all of Denver; William N. Baker, George A. Unfug, Pueblo; George G. Balderston, Montrose; Lee J. Beuchat, Trinidad; Lawrence D. Buchanan, Wray; Guy E. Calonge, La Junta; Norman L. Currie, Burlington; L. L. Hick, Delta; Paul R. Hildebrand, Brush; Fred D. Kuykendall, Eaton; James M. Lamme, Jr., Walsenburg; Robert C. Lewis, Jr., Aspen; Mason Light, Gunnison; James S. Haley, Longmont; Harlan E. McClure, Lamar; Franklin J. McDonald, Leadville; Ben H. Mayer, Steamboat Springs; Edward G. Merritt, Dolores; G. C. Milligan, Englewood; C. W. Vickers, Del Norte; A. D. Waroshill, Florence; W. Lloyd Wright, Golden; Theodore E. Heinz, Greeley; John D. Gillaspie, Boulder; Kenneth E. Gloss, John W. Bradley, John L. McDonald, R. C. Vanderhoof, all of Colorado Springs, Kenneth E. Prescott, Geno Saccomanno, Grand Junction.

Military Affairs Committee: Robert S. Liggett, Chairman; Claude D. Bonham, George R. Buck, John M. Foster, all of Denver; Calvin N. Caldwell, Pueblo; Ward C. Fenton, Rocky Ford; Leo W. Lloyd, Durango; W. B. Crouch, Colorado Springs; Harvey M. Tupper, Grand Junction.

Nursing Education Problems: Harold D. Palmer, Chairman; Kenneth C. Sawyer, E. Paul Sheridan, John R. Evans, Ervin A. Hinds, Fred Hartshorn, Douglas R. Collier, all of Denver; Russell H. Hanson, Boulder; Harry C. Bryan, Colorado Springs; John J. Yaeger, Pueblo; E. H. Munro, Grand Junction; Richard L. Davis, La Junta.

Organization Study Committee: Lawrence D. Buchanan, Chairman, Wray, Bradford Murphey, Vice Chairman, Denver; John S. Bouslog, Denver; Archer C. Sudan, Grand Junction; William A. Campbell, Colorado Springs; George A. Unfug, Pueblo; Arthur B. Gjellum, Del Norte; John A. Weaver, Greeley; Jackson L. Sadler, Fort Collins.

SPECIAL REPRESENTATIVES

Representative to Rocky Mountain Radio Council: John S. Bouslog, Denver.

Representative to Adult Education Council: John A. Edwards, Denver; Richard B. Greenwood, Denver.

MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL MEETING: BUTTE, SEPTEMBER 16-19, 1954

OFFICERS, 1953-1954

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at 1954 Annual Session.

President: Sidney C. Pratt, 6 North 7th, Miles City.

President-Elect: J. J. Malee, 101 Main Street, Anaconda.

Vice President: George W. Setzer, Malta.

Secretary-Treasurer: T. R. Vye, 412 North Broadway, Billings.

Assistant Secretary-Treasurer: Park W. Willis, Jr., 215 Main Street, Hamilton.

Executive Secretary: Mr. L. R. Hegland, 1236 N. 28th Street, Billings.

Delegate to American Medical Association: R. F. Peterson, 9 West Granite, Butte.

Alternate Delegate to American Medical Association: Thomas L. Hawkins, 555 Fuller Avenue, Helena.

STANDING COMMITTEES

Executive Committee: S. C. Pratt, Chairman, Miles City; James M. Flinn, Helena; J. J. Malee, Anaconda; Frank L. McPhail, Great Falls; George W. Setzer, Malta; T. R. Vye, Billings; Park W. Willis, Jr., Hamilton.

Economic Committee: D. S. MacKenzie, Jr., Chairman, Havre; Raymond E. Benson, Billings; Leonard W. Brewer, Missoula; Paul J. Gans, Lewistown; David Gregory, Glasgow; William E. Harris, Livingston; Robert J. Holzberger, Great Falls; John E. Low, Sidney.

Legislative Committee: Amos R. Little, Jr., Chairman, Helena; David T. Berg, Helena, 1956; Herbert T. Caraway, Billings, 1955; William F. Cashmore, Helena, 1955; C. H. Fredrickson, Missoula, 1956; M. A. Gold, Butte, 1954; A. M. Lueck, Livingston, 1954.

Necrology and History of Medicine Committee: E. S. Murphy, Chairman, Missoula; R. D. Benson, Sidney; M. G. Danskin, Billings; Albert A. Dodge, Kalispell; E. M. Gans, Harlowton; William G. Richards, Billings; John P. Ritchey, Missoula; James I. Wernham, Billings.

Public Relations Committee: Park W. Willis, Jr., Chairman, Hamilton, 1955; Albert W. Axley, Havre, 1955; E. H. Lindstrom, Helena, 1954; C. S. Meeker, Butte, 1954; C. R. Svore, Missoula, 1956; A. L. Vadheim, Jr., Bozeman, 1956; George D. Waller, Jr., Cut Bank, 1956; M. D. Winter, Miles City, 1954; John A. Whittinghill, Billings, 1955; S. A. Cooney, Helena, Ex-officio.

Legal Affairs and Malpractice Committee: Louis W. Allard, Chairman, Billings; John H. Bridenbaugh, Billings; Fritz D. Hurd, Great Falls; Robert E. Mattison, Billings; Park W. Willis, Jr., Hamilton.

Program Committee: Thomas W. Saam, Chairman, Butte; John A. Layne, Vice-Chairman, Great Falls; Deane C. Epler, Bozeman; Roger A. Larson, Billings; Stephen N. Preston, Missoula; Theodore R. Vye, Billings, Ex-officio.

Interprofessional Relations Committee: George A. Sexton, Chairman, Great Falls; Louis W. Allard, Billings; Richard O. Chambers, Glendive; John K. Colman, Butte; Thomas L. Hawkins, Helena; Francis I. Sabo, Bozeman.

Nominating Committee: C. R. Svore, Chairman, Missoula; M. A. Gold, Butte; Wayne Gordon, Billings; Wyman J. Roberts, Great Falls; William A. Treat, Miles City.

Auditing Committee: George M. Donich, Chairman, Anaconda; Leonard M. Benjamin, Deer Lodge; Robert D. Knapp, Wolf Point; John J. Mitschke, Helena; George G. Sale, Missoula.

Mediation Committee: Frederic S. Marks, Chairman, Billings, 1954; H. M. Clemmons, Butte, 1955; Harold W. Fuller, Great Falls, 1956; Exner P. Higgins, Kalispell, 1954; Chester W. Lawson, Havre, 1955; James J. McCabe, Helena, 1954; George J. Moffitt, Livingston, 1956; E. S. Murphy, Missoula, 1955; R. W. Polk, Miles City, 1956.

Cancer Committee: Harold W. Gregg, Chairman, Butte; Walter B. Cox, Missoula; Deane C. Epler, Bozeman; Chester W. Lawson, Havre; Stuart A. Olson, Glendive; Philip D. Pallister, Boulder; Edwin C. Segard, Billings.

Maternal and Child Welfare Committee: Earl L. Hall, Chairman, Great Falls.

Subcommittee on Obstetrics: Glenn A. Carmichael, Chairman, Missoula; J. E. Brann, Kalispell; Harry B. Campbell, Missoula; Maude M. Gerdes, Billings; Elna M. Howard, Miles City; Charles W. Pemberton, Butte.

Subcommittee on Pediatrics: Donald L. Gillespie, Chairman, Butte; George H. Barmeyer, Missoula; Roger W. Clapp, Butte; Frank J. Friden, Great Falls; Harry J. Lawler, Billings; Orville M. Moore, Helena; R. Wynne Morris, Helena; George W. Nelson, Billings; Philip D. Pallister, Boulder; Paul R. Ensign, Helena, Ex-officio.

Tuberculosis Committee: Harry V. Gibson, Chairman, Great Falls; Malcolm O. Burns, Kalispell; Roger W. Clapp, Butte; H. M. Clemmons, Butte; Alfred M. Fulton, Billings; Donald D. Gnose, Missoula; John M. Nelson, Missoula; Frank M. Petkevich, Great Falls; Frank I. Terrill, Galen; L. S. McLean, Helena, Ex-officio.

Fracture and Orthopedic Committee: John C. Wolgamot, Chairman, Great Falls; L. Clayton Allard, Billings; Louis W. Allard, Billings; H. M. Clemmons, Butte; John K. Colman, Butte; Walter H. Hagen, Billings; Charles F. Honeycutt, Missoula; Stephen L. Odgers, Missoula; Paul R. Ensign, Helena, Ex-officio.

Rural Health Committee: B. C. Farrand, Chairman, Jordan; Henry J. Borge, Wolf Point; Charles P. Brooke, Missoula; David Gregory, Glasgow; Raymond G. Johnson, Harlowton; B. K. Kilbourne, Hardin; Ronald E. Losee, Ennis; Walter G. Tanglin, Polson; George E. Trobough, Anaconda; L. S. McLean, Helena, Ex-officio.

Industrial Welfare Committee: Russell B. Richardson, Chairman, Great Falls; David J. Almas, Havre; Theodore W. Cooney, Helena A. R. Kintner, Missoula; William F. Morrison, Missoula; L. F. Rotar, Butte; James G. Sawyer, Butte; Paul J. Sullivan, Billings; Frank K. Waniata, Great Falls; G. D. Cariyle Thompson, Helena, Ex-officio.

Rheumatic Fever and Heart Committee: F. R. Schemm, Chairman, Great Falls; Deane C. Epler, Bozeman; John S. Gilson, Great Falls; M. A. Gold, Butte; Elizabeth Grimm, Billings; B. A. Lucking, Helena; Harold E. McIntyre, Billings; C. S. Meeker, Butte; Orville M. Moore, Helena; Richard D. Weber, Missoula; G. D. Cariyle Thompson, Helena, Ex-officio.

Rocky Mountain Medical Conference Committee: Herbert T. Caraway, Chairman, Billings, 1954; H. M. Blegen, Missoula, 1955; Charles B. Craft, Bozeman, 1956; M. A. Gold, Butte, 1958; Frank K. Waniata, Great Falls, 1957; Sidney C. Pratt, Miles City, Ex-officio; Theodore R. Vye, Billings, Ex-officio.

Public Health Committee: J. J. Malee, Chairman, Anaconda; B. C. Farrand, Jordan; Harry V. Gibson, Great Falls; Harold W. Gregg, Butte; Earl L. Hall, Great Falls; A. R. Kintner, Missoula; Raymond F. Peterson, Butte; R. B. Richardson, Great Falls; Ferdinand R. Schemm, Great Falls; John W. Schubert, Lewistown; George A. Sexton, Great Falls; Walter G. Tanglin, Polson; Thomas F. Walker, Jr., Great Falls; Winfield S. Wilder, Great Falls; John C. Wolgamot, Great Falls.

Hospital Relations Committee: Raymond F. Peterson, Chairman, Butte; Walter B. Cox, Missoula; Thomas L. Hawkins, Helena; William W. McLaughlin, Great Falls; Francis P. Nash, Townsend; Stuart A. Olson, Glendive; Grant P. Raitt, Billings; Edwin C. Segard, Billings.

SPECIAL COMMITTEES

Arthritis and Rheumatism Committee: Ralph H. Biehn, Chairman, Billings; Betty S. Gibson, Great Falls; A. R. Kintner, Missoula; Thomas F. Walker, Jr., Great Falls; M. D. Winter, Miles City.

Committee on Blood Banks: Mary E. Martin, Chairman, Billings; H. M. Blegen, Missoula; William W. McLaughlin, Great Falls; Raymond F. Peterson, Butte.

Emergency Medical Service Committee: John W. Schubert, Chairman, Lewistown; J. H. Brancamp, Butte; T. D. Callan, Anaconda; John C. Hanley, Great Falls; Harrison D. Huggins, Kalispell; A. J. Marchello, Billings; George G. Sale, Missoula; Stuart D. Whetstone, Cut Bank; G. D. Cariyle Thompson, Helena, Ex-officio.

Committee on Medical Education: Everett H. Lindstrom, Chairman, Helena; Leonard W. Brewer, Missoula; L. L. Howard, Great Falls; Frank L. McPhail, Great Falls; James D. Morrison, Billings.

Mental Hygiene Committee: Winfield S. Wilder, Chairman, Great Falls; Joseph W. Brinkley, Great Falls; James J. Bulger, Great Falls; Gladys V. Holmes, Missoula; M. A. Ruona, Billings.

School Health Committee: Ray O. Bjork, Chairman, Helena; George M. Donich, Anaconda; David F. Hall, Butte; Earl L. Hall, Great Falls; E. P. Higgins, Kalispell; Chester W. Lawson, Havre; Stuart A. Olson, Glendive; C. R. Svore, Missoula.

Committee on Veterans Affairs: C. H. Fredrickson, Chairman, Missoula; Malcolm O. Burns, Kalispell; Fritz D. Hurd, Great Falls; John E. Hynes, Billings; Ray O. Lewis, Helena; Raymond F. Peterson, Butte.

Advisory Committee on Courses for Medical Secretaryships: David J. Almas, Chairman, Havre; E. K. George, Missoula; Edward W. Gibbs, Billings; Herbert H. James, Butte; Ronald G. Keeton, Bozeman; Otto G. Klein, Helena; Neil M. Leitch, Kalispell; George B. LeTellier, Lewistown; Frank K. Waniata, Great Falls.

REPRESENTATIVES OF MONTANA MEDICAL ASSOCIATION TO OTHER STATE AND NATIONAL ORGANIZATIONS

Montana Committee for Employment of Physically Handicapped: Stephen L. Odgers, Missoula.

Joint Committee of Health Problems in Education of the National Education Association and the American Medical Association: Ray O. Bjork, Helena.

State Committee for Student Affiliation in the Field of Public Health: L. S. McLean, Helena.

State Board of Eugenics: Gladys V. Holmes, Missoula; Sidney C. Pratt, Miles City.

Montana Health Planning Council: Park W. Willis, Jr., Hamilton; Walter G. Tanglin, Polson.

American Medical Education Foundation: Chester W. Lawson, Havre, Chairman for Montana.

Advisory Committee on Narcotic and Alcohol Education: Theodore W. Cooney, Helena; Winfield S. Wilder, Great Falls.

Rocky Mountain Medical Journal: Raymond F. Peterson, Butte, Scientific Editor for Montana; Mr. L. R. Hegland, Associate Editor for Montana.

Meat...

and the Dietary Treatment of Gastrointestinal Disorders

A recent study points out that patients with peptic ulcer, ulcerative colitis or regional enteritis can effectively utilize good quality protein from animal sources.* Protein hydrolysates apparently are less effectively utilized than intact protein.

In patients with uncomplicated peptic ulcer on regimens providing intact animal proteins the patterns of amino acid excretion in urine and feces were similar to those in normal subjects. In patients with ulcerative colitis or regional enteritis the increased output of nitrogen and amino acids in the feces was attributed to loss of intestinal secretions, inflammatory exudate, and blood. Although the patients utilized intact animal proteins effectively, the authors suggested that an intake of more than one gram of dietary protein per kilogram of body weight might be useful.

On the basis of this study a dietary plan recommended for treatment of gastrointestinal disorders provides at least one gram, of protein per kilogram of body weight, but preferably more. Meat constitutes one of the important sources of animal protein in the plan.

In dietotherapy, meat serves many important physiologic and nutritional functions. Its appetizing flavor animates the desire to eat and promotes good digestion. Meat is easily and almost completely digested. Its high content of protein provides goodly amounts of all the essential amino acids well supplemented with others. Meat also contributes valuable amounts of many B vitamins and of essential minerals, especially iron, phosphorus, and potassium.

---

*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, J. Am. Dietet. A. 29:1103 (Nov.) 1953.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

NEW MEXICO MEDICAL SOCIETY

NEXT ANNUAL SESSION: ALBUQUERQUE, MAY 5, 6, 7, 1955
(Joint Meeting with Rocky Mountain Medical Conference)

OFFICERS, 1954-55

President: John F. Conway, Clovis.

Immediate Past President: Albert S. Lathrop, Santa Fe.

President-Elect: Stuart W. Adler, Albuquerque.

Vice President: Earl L. Malone, Roswell.

Secretary-Treasurer: Lewis M. Overton, Albuquerque.

Executive Secretary: Mr. Ralph R. Marshall, 223-24 First National Bank Bldg., Albuquerque. Phone 2-2102.

Councilors (three years): W. D. Dabbs, Clovis; W. E. Badger, Hobbs; (two years): Carl H. Gellenthien, Valmora; R. C. Derbyshire, Santa Fe; (one year): J. C. Sedgwick, Las Cruces; W. O. Connor, Jr., Albuquerque.

Delegate to American Medical Association (two years): H. L. January, Albuquerque. **Alternate:** Coy S. Stone, Hobbs.

COMMITTEES, 1954-55

Board of Trustees, New Mexico Physicians' Service: President John F. Conway, Clovis; Secretary-Treasurer L. G. Rice, Jr., Albuquerque; C. H. Gellenthien, Valmora; H. L. January, Albuquerque; A. S. Lathrop, Santa Fe; I. J. Marshall, Roswell; L. J. Whitaker, Deming; C. L. Womack, Carlsbad; Fred Hanold, Albuquerque; L. L. Daviet, Las Cruces; C. S. Stone, Hobbs; Albert Simms, Albuquerque; W. R. Oakes, Las Alamos; J. H. Dettweiler, Albuquerque; R. P. Beaudette, Raton; Mr. L. J. Lagrave, Executive Director, 212 Insurance Building, Albuquerque. Phone 3-3188.

Board of Supervisors (two years): Guy Rader, Albuquerque; G. A. Slusser, Artesia, Secretary; S. R. Ziegler, Espanola; Vincent Accardi, Gallup; (one year): George Prothro, Clovis, Chairman; E. W. Lander, Roswell; Milton Floersheim, Raton; N. D. Frazin, Silver City.

Nominating Committee: Victor K. Adams, Raton; S. R. Ziegler, Espanola; Fred Hanold, Albuquerque; W. D. Dabbs, Clovis; Earl Malone, Roswell; Leland S. Evans, Las Cruces.

Legislative and Public Policy Committee: R. C. Derbyshire, Santa Fe, Co-Chairman; W. O. Connor, Jr., Albuquerque, Co-Chairman; C. L. Womack, Carlsbad; R. P. Beaudette, Raton; H. W. Hodde, Hobbs; I. J. Marshall, Roswell; Ashley Pond, Taos; E. M. Warner, Tucumcari; W. D. Dabbs, Clovis; J. A. Rivas, Belen; L. L. Daviet, Las Cruces; L. F. Hamilton, Artesia; W. J. Hossley, Deming; W. E. Oakes, Los Alamos; R. E. Watts, Silver City; J. A. Evans, Las Vegas; Wendell Peacock, Farmington.

Public Relations Committee: Leland S. Evans, Las Cruces, Chairman; R. P. Beaudette, Raton; H. L. January, Albuquerque; O. G. Fischer, Farmington; F. W. Parker, Gallup; U. S. Marshall, Roswell; M. Zenos Smith, Socorro; George Prothro, Clovis; J. A. Evans, Las Vegas; C. L. Womack, Carlsbad; W. J. Hossley, Deming; R. V. Seligman, Albuquerque.

Welfare and Indigent Medical Care Committee: S. R. Ziegler, Espanola, Chairman; D. H. Cahoon, Roswell; M. J. Smith, Santa Fe; J. G. Strance, Albuquerque; L. M. Overton, Albuquerque.

Professional Insurance Committee: L. M. Overton, Albuquerque, Chairman; G. A. Slusser, Artesia; Omar Legant, Albuquerque.

Advisory Committee to Selective Service: H. L. January, Albuquerque, Chairman; G. S. Morrison, Roswell; R. L. Young, Santa Fe.

American Medical Education Foundation: I. J. Marshall, Roswell, State Chairman.

Rural Health Committee: Michel Pijoan, Espanola, State Chairman.

Rocky Mountain Medical Conference Committee: H. L. January, Albuquerque, Chairman.

DISTINCTIVE AMONG POTENT HYPOTENSIVES FOR THESE

14 DESIRABLE PROPERTIES... Veriloid®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

A selective alkaloidal extract of hypotensive principles obtained by fractionation from Veratrum viride. Representing less than 1% of the whole root, it is freed from the dross of the mother substance. It is generically designated alkavervir. In the management of hypertension it presents these desirable properties.

1 Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

2 Blood pressure is lowered by centrally medicated action; there is no ganglionic or adrenergic blocking.

3 Therapy is rarely, if ever, fraught with the danger of postural hypotension.

4 Hypotensive action is independent of alterations in heart rate.

5 Cardiac output is not reduced.

6 Renal function, unless previously grossly reduced, is not compromised.

7 Cerebral blood flow is not decreased.

8 Cardiac work is not increased, tachycardia is not engendered.

9 No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily overcome and thereafter avoided by dosage adjustment.

10 In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

12 Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

13 Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

14 A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

Tablets Veriloid

The slow-dissolving, scored tablets are supplied in 2 mg. and 3 mg. potencies. In moderate to severe hypertension they produce gratifying response in many patients. According to published reports[1] this response can be maintained for long periods in fully 30% of patients; combination with other hypotensive agents has been credited with greatly increasing this percentage.[2] Initial daily dosage 9 mg., given in divided doses, not less than 4 hours apart, preferably after meals. To be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.[3] If excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations which do not show the same immediate urgency. Provides 1.0 mg. of Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers the blood pressure significantly, reaching its maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary.[4] Supplied in boxes of six 2 cc. ampuls. Complete instructions as to dosage and administration accompany every ampul of the parenteral preparations of Veriloid and should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of Intravenous Administration of a Preparation of Veratrum Viride in Patients with Severe Forms of Hypertensive Disease, New England J. Med. *246*:397 (Mar. 13) 1952.
4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, Am. J. M. Sc. 226:477 (Nov.) 1953.

ORIGINAL RESEARCH PRODUCTS OF

RIKER LABORATORIES, INC. 8480 Beverly Boulevard; Los Angeles 48, California

THE UTAH STATE MEDICAL ASSOCIATION

OFFICERS, 1953-1954

President: Frank K. Bartlett, Ogden.

President-Elect: Charles Ruggeri, Salt Lake City.

Past President: K. B. Castleton, Salt Lake City.

Honorary President: L. S. Merrill, Ogden.

Secretary: Homer E. Smith, Salt Lake City.

Executive Secretary: Mr. Harold Bowman, Salt Lake City.

Treasurer: J. R. Miller, Salt Lake City.

Councilor, Cache Valley Medical Society: R. O. Porter, Logan.

Councilor, Carbon County Medical Society: J. Eldon Dorman, Price.

Councilor, Central Utah Medical Society: R. N. Malouf, Richfield.

Councilor, Salt Lake County Medical Society: V. L. Rees, Salt Lake City.

Councilor, Southern Utah Medical Society: R. G. Williams, Cedar City.

Councilor, Uintah Basin Medical Society: T. R. Seager, Vernal.

Councilor, Utah County Medical Society: D. E. Ostler, Provo.

Councilor, Weber County Medical Society: Rich Johnston, Ogden.

Delegate to A.M.A., 1954 and 1955: Geo. M. Fister, Ogden.

Alternate Delegate to A.M.A., 1954 and 1955: Elliot Snow, Salt Lake City.

Editor of the Utah Section of the Rocky Mountain Medical Journal: R. P. Middleton, Salt Lake City.

Board of Supervisors: 1954, J. C. Hubbard, Price; 1955, J. G. Olson, Ogden; 1956, C. J. Daines, Logan; 1957, R. E. Jorgenson, Provo.

STANDING COMMITTEES

Rocky Mountain Medical Conference Continuing Committee: 1954, R. P. Middleton, Chairman, Salt Lake City; 1955, U. R. Bryner, Salt Lake City; 1956, Heber C. Hancock, Ogden; 1957, Wm. H. Moretz, Salt Lake City; 1958, Robert G. Snow, Salt Lake City.

Scientific Program Committee: Homer E. Smith, Chairman, Salt Lake City.

Medical Defense Committee: 1954, Fuller Bailey, Salt Lake City; 1954, Reed Harrow, Salt Lake City; 1954, H. R. Reichman, Salt Lake City; 1955, Wm. M. Nebeker, Chairman, Salt Lake City; 1955, G. S. Francis, Wellsville; 1955, Donald V. Poppen, Provo; 1956, Paul K. Edmunds, Cedar City; 1956, Oscar Ernest Grua, Ogden.

Medical Education and Hospitals Committee: 1954, Harry J. Brown, Chairman, Provo; 1954, L. K. Gates, Logan; 1954, K. A. Crockett, Salt Lake City; 1955, R. V. Larsen, Roosevelt; 1955, Mark B. Jensen, Castle Gate; 1955, J. B. Cluff, Richfield; 1955, W. J. Reichman, St. George; 1956, E. D. Zeman, Ogden; 1956, P. M. Gonzales, Price; 1957, E. G. Holmstrom, Salt Lake City; 1957, Philip Price, Salt Lake City; 1957, John A. Gubler, Salt Lake City.

Medical Economics Committee: 1954, Geo. C. Ficklin, Tremonton; 1954, J. H. Millburn, Tooele; 1955, Ralph N. Barlow, Chairman, Logan; 1955, Thomas R. Broadbent, Salt Lake City; 1955, A. W. Middleton, Salt Lake City.

Procurement and Assignment Committee: Elliot Snow, Chairman, Salt Lake City; Frank K. Bartlett, Ogden; John J. Galligan, Salt Lake City; John H. Clark, Salt Lake City; J. Russell Smith, Provo.

SPECIAL COMMITTEES ALLIED TO PUBLIC HEALTH

General Committee on Public Health: Frank J. Winget, Chairman, Salt Lake City; C. H. H. Branch, Salt Lake City; Geo. H. Curtis, Salt Lake City; Robt. S. Rothwell, Salt Lake City; Glen R. Leymaster, Salt Lake City; Nephi K. Kezerian, Provo; Ralph C. Ellis, Ogden; R. W. Farnsworth, Cedar City.

Committee on Fractures: Nephi K. Kezerian, Chairman, Provo; Wallace E. Hess, Salt Lake City; Chas. M. Swindler, Ogden.

Cancer Committee: Ralph C. Ellis, Chairman, Ogden; H. B. Fowler, Vernal; Geo. W. Gasser, Logan; Shelley A. Swift, Salt Lake City; David Garth Edmunds, Salina.

Committee on Sewage, Water and Air Pollution: Glenn R. Leymaster, Chairman, Salt Lake City; Chas. M. Smith, Provo; John Smith, Duchesne; G. S. Rees, Gunnison; Russell N. Hirst, Ogden; J. Clair Hayward, Logan; Quinn Whiting, Price; J. S. Prestwich, Cedar City.

Committee on Tuberculosis and Cardio Vascular Diseases: George N. Curtis, Chairman, Salt Lake City; Keith Farr, Ogden; Merrill C. Daines, Logan; L. Wayland Macfarlane, Salt Lake City; C. W. Sorenson, Salt Lake City.

Committee on Rural Health: R. W. Farnsworth, Chairman, Cedar City; J. Howard Rasmussen, Co-Chairman, Brigham City; Paul G. Stringham, Roosevelt; Milo C. Moody, Spanish Fork; Kurt L. Jenkins, Marysvale;

Committee on School Health: Robert S. Rothwell, Chairman, Salt Lake City; R. W. Sonntag, Salt Lake City; Geo. B. Ely, Salt Lake City; Roy A. Darke, Salt Lake City; Grant H. Way, Ogden; Roy B. Hammond, Provo; Jane Fowler, Vernal.

Committee on Mental Health: Chas. H. Branch, Chairman, Salt Lake City; L. G. Moench, Salt Lake City; E. M. Kilpatrick, Salt Lake City; Owen P. Heninger, Provo; Wm. D. O'Gorman, Ogden.

Industrial Health Committee: Frank J. Winget, Chairman, Salt Lake City; Geo. A. Spendlove, Salt Lake City; Paul S. Richards, Salt Lake City; Byron Daynes, Salt Lake City; Ralph Tingey, Salt Lake City; L. H. Merhill, Hiawatha; H. C. Jenkins, Bingham Canyon, Rulon Howe, Ogden.

SPECIAL COMMITTEES ALLIED TO PUBLIC RELATIONS

General Committee on Public Relations: James Z. Davis, Chairman, Salt Lake City; Drew Peterson, Ogden; Wallace Brooke, Salt Lake City; Fred W. Clausen, Salt Lake City; R. P. Middleton, Salt Lake City.

Legislative Committee: James Z. Davis, Chairman, Salt Lake City; Dean C. Evans, Fillmore; R. M. Muirhead, Salt Lake City; John Z. Bowers, Salt Lake City; Geo. A. Spendlove, Salt Lake City; L. V. Broadbent, Cedar City; P. M. Gonzales, Helper; J. G. McQuarrie, Richfield; Ray E. Spendlove, Vernal; Eugene L. Wiemers, Pleasant Grove; Robert Budge, Smithfield; Clark Rich, Ogden.

Committee on Utah Health Council: Drew Peterson, Ogden; N. F. Hicken, Salt Lake City; L. E. Viko, Salt Lake City; H. R. Reichman, Salt Lake City; K. B. Castleton, Ex-Officio, Salt Lake City; Paul Clayton, Salt Lake City.

Committee on Relations With Press, Radio and Television: Wallace Brooke, Chairman, Salt Lake City; Donald Moore, Ogden; R. H. Wakefield, Provo; J. Clair Hayward, Logan; L. H. Merrill, Hiawatha; Irving Ershler, Salt Lake City.

Committee on Insurance Plans: Fred W. Clausen, Chairman, Salt Lake City; John Z. Brown, Jr., Salt Lake City; Robt. D. Beech, Salt Lake City; Robert G. Snow, Salt Lake City; John H. Clark, Salt Lake City; Clair Hayward, Logan.

Newspaper Health Column Committee: R. P. Middleton, Chairman, Salt Lake City; Edwin Zeman, Ogden; L. W. Oaks, Provo; T. C. Bauerlein, Salt Lake City; W. H. Moretz, Salt Lake City; M. E. Bird, Delta.

SPECIAL COMMITTEES

Civilian Defense Committee: Leslie J. Paul, Chairman, Salt Lake City; S. M. Budge, Logan; LeRoy A. Wirthlin, Salt Lake City; L. W. Benson, Ogden; Riley G. Clark, Provo; Geo. Spendlove, Salt Lake City.

Constitution and By-Laws Committee: J. Russell Smith, Chairman, Provo; James M. Catlin, Ogden; W. W. Barrett, Helper; R. O. Johnson, Murray; Garner B. Meads, Salt Lake City; Heber Hancock, Ogden; James Cleary, Salt Lake City.

Fee Schedule Committee: Wm. Ray Rumel, Chairman, Salt Lake City.

Blood Bank Committee: M. W. Wintrobe, Chairman, Salt Lake City. Plus the chairman of the Blood Bank Committee of each Component Society.

Advisory Committee to Woman's Auxiliary: Frank K. Bartlett, Chairman, Ogden; Charles Ruggeri, Salt Lake City; K. B. Castleton, Salt Lake City; Homer E. Smith, Salt Lake City; J. R. Miller, Salt Lake City; R. O. Porter, Logan; J. Eldon Dorman, Price; R. N. Malouf, Richfield; V. L. Rees, Salt Lake City; R. G. Williams, Cedar City; T. R. Seager, Vernal; D. E. Ostler, Provo; Rich Johnston, Ogden.

Necrology Committee: James K. Palmer, Salt Lake City.

Labor Relations Committee: V. L. Rees, Chairman, Salt Lake City; James McClintock, Dragerton; A. L. Graff, Cedar City; Quinn Whiting, Price; Frank K. Winget, Salt Lake City; E. M. Kilpatrick, Salt Lake City; Rulon M. Howe, Ogden; Boyd J. Larson, Lehi.

Rheumatic Fever Committee: E. M. Kilpatrick, Chairman, Salt Lake City; Stanley Child, Salt Lake City; Homer Rich, Ogden; L. E. Viko, Salt Lake City; Geo. Spendlove, Salt Lake City; R. W. Farnsworth, Cedar City; W. E. Peltzer, Salt Lake City.

Veterans Affairs Committee: Vernon Stevenson, Chairman, Salt Lake City; Vernal H. Johnson, Ogden; John H. Rupper, Provo.

Special Liaison Committee to Allied Professions: Charles Ruggeri, Chairman, Salt Lake City; Wm. M. Nebeker, Salt Lake City; T. C. Weggeland, Salt Lake City; Eugene Wood, Salt Lake City; Dean Tanner, Ogden.

Committee on Aid to the Aged: V. L. Ward, Chairman, Ogden; J. J. Weight, Provo; A. J. Lund, Ogden; Victor Kassell, Salt Lake City; T. R. Gledhill, Richfield; L. W. Sorenson, Parowan; D. T. Madsen, Price.

Committee on Accident Prevention: W. H. Anderson, Chairman, Ogden; J. P. Bartlett, Ogden; Ralph N. Barlow, Logan; W. Ezra Cragun, Logan; W. R. Young, Salt Lake City; Nomma Randall, Salt Lake City; Leonard H. Taboroff, Salt Lake City; Joseph P. Kesler, Salt Lake City; A. M. Okelberry, Salt Lake City; Woodrow Nelson, Salt Lake City; R. H. Wakefield, Provo; M. K. McGregor, St. George; Tyrell R. Seager, Vernal; R. N. Malouf, Richfield; Eugene Davis, Milford; E. S. McQuarrie, Beaver.

Which filter-tip cigarette is the most effective?

In continuing and repeated impartial scientific tests, smoke from the new KENT consistently proves to have much less nicotine and tar than smoke from any other filter cigarette—old or new.

The reason is KENT's exclusive Micronite Filter.

This new filter is made of a filtering material so efficient it has been used to purify the air in atomic energy plants of microscopic impurities.

Adapted for use as a cigarette filter, it removes nicotine and tar particles as small as 2/10 of a micron.

And yet KENT's Micronite Filter, which removes a greater percentage of nicotine and tar than any other filter cigarette, lets through the full flavor of KENT's fine tobaccos.

Because so much evidence indicates KENT is the most effective filter-tip cigarette, shouldn't it be the choice of those who want the minimum of nicotine and tar in their cigarette smoke?

Kent with the exclusive Micronite Filter

THE WYOMING STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: SHERIDAN, JUNE 7, 8, AND 9, 1954

OFFICERS

President: B. J. Sullivan, Laramie.

President-elect: Russell I. Williams, Cheyenne.

Vice President: Joseph S. Hellewell, Evanston.

Secretary: Harlan B. Anderson, Casper.

Treasurer: Carleton D. Anton, Sheridan.

Delegate to A.M.A.: W. Andrew Bunten, Cheyenne.

Alternate Delegate to A.M.A.: Albert T. Sudman, Green River.

Executive Secretary: Arthur R. Abbey, Cheyenne.

Councillors: Paul R. Holtz, 1955, Lander (Chairman); Earl Whedon, 1955, Sheridan; Joseph F. Whalen, 1956, Evanston; J. Cedric Jones, 1956, Cody; Glenn O. Beach, 1956, Casper; Francis A. Barrett, 1957, Cheyenne; Joseph E. Hoadley, 1957, Gillette; Ex-Officio: B. J. Sullivan, President, Laramie; Harlan B. Anderson, Secretary, Casper.

COMMITTEES

Public Relations Committee: Nels Vicklund, Chairman, Thermopolis; Members—All County Medical Society Presidents.

Committee for Professional Review: J. Cedric Jones, Chairman, 1955, Cody; Roscoe H. Reeve, 1955, Casper; David Flett, 1954, Cheyenne; Albert Sudman, 1956, Green River.

Elected Medical Defense Committee: Karl E. Krueger, Chairman, 1954, Rock Springs; Paul R. Holtz, 1955, Lander; Ed Guilfoyle, 1956, Newcastle.

Advisory Committee to Selective Service on Procurement and Assignment of Physicians: Sam Zuckerman, Chairman, 1955, Cheyenne; Roscoe H. Reeve, 1954, Casper; Joseph A. Gautsch, 1956, Cody.

Veterans Affairs and Military Service Committee: Louis G. Booth, Chairman, Sheridan; (Members to be assigned at a later date).

Blue Cross Hospital Committee: Russel Williams, Chairman, 1954, Cheyenne; Roscoe H. Reeve, 1955, Casper; DeWitt Dominick, 1956, Cody; L. H. Wilmoth, 1957, Lander.

Blue Shield Committee: G. W. Koford, Chairman, Cheyenne; H. E. Stuckenhoff, Casper; K. L. McShane, Cheyenne; J. Cedric Jones, Cody.

Medical Economics Committee: Carelton D. Anton, Chairman, Sheridan; Nels Vicklund, Thermopolis; A. J. Allegretti, Cheyenne; E. E. Pelton, Laramie.

Rocky Mountain Medical Conference: H. L. Harvey, Chairman, 1954, Casper; Earl Whedon, 1955, Sheridan; George H. Phelps, 1955, Cheyenne; Don MacLeod, 1956, Jackson.

Advisory Committee to Woman's Auxiliary: Ed J. Guilfoyle, Chairman, Newcastle; J. E. Clark, Casper; W. H. Pennover, Cheyenne.

Public Policy and Legislation: DeWitt Dominick, Chairman, 1956, Cody; G. W. Koford, 1955, Cheyenne; George H. Phelps, 1954, Cheyenne; E. W. DeKay, 1955, Laramie; L. H. Wilmoth, 1954, Lander; C. D. Anton, 1956, Sheridan; E. W. Gardner, 1956, Douglas.

State Institutions Advisory Committee: Joseph F. Whalen, Chairman, Evanston; Franklin D. Yoder, Cheyenne; R. H. Knable, Basin; C. W. Jeffrey, Rawlins; L. H. Wilmoth, Lander.

Council on National Emergency Medical Service Civil Defense: George H. Phelps, Chairman, 1955, Cheyenne; Roscoe H. Reeve, 1955, Casper; E. W. DeKay, 1954, Laramie; P. M. Schunk, 1954, Sheridan; Barnard Stack, 1956, Riverton; Richard Stratton, 1956, Green River; Benjamin Gitlitz, 1956, Thermopolis.

Judicial and Advisory Committee (Workmen's Compensation): District No. 1, George H. Phelps, 1955, Cheyenne; Paul J. Preston, 1956, Cheyenne; K. N. Petri, 1956, Laramie; District No. 2, Karl Krueger, 1954, Rock Springs; District No. 3, John H. Waters, 1954, Evanston; District No. 4, Curtis L. Rogers, 1955, Sheridan; District No. 5, G. M. Groshart, 1954, Worland; District No. 6, O. E. Torkelson, 1956, Lusk; District No. 7, F. H. Haigler, Chairman, 1955, Casper.

American Medical Education Foundation: J. Cedric Jones, Chairman, 1955, Cody; B. J. Sullivan, 1954, Laramie; Glen O. Beach, 1956, Casper.

Necrology Committee: Earl Whedon, Chairman, Sheridan; Franklin D. Yoder, Cheyenne.

Public Health-Liaison Committee: E. Chester Ridgway, Chairman, Cody; H. B. Rae, Torrington; Dale Ashbaugh, Riverton; Guy M. Halsey, Rawlins.

Maternal Welfare: L. D. Kattenhorn, Chairman, Powell; L. H. Wilmoth, Lander; E. D. Kunckel, Casper; G. W. Koford, Cheyenne; W. M. Franz, Newcastle; O. J. Rojo, Sheridan.

Child Health Committee: Lawrence J. Cohen, Chairman, Cheyenne; Lucile B. Kirtland, Monarch; O. K. Scott, Casper; L. F. Allison, Powell.

Syphilis Committee: L. H. Wilmoth, Chairman, Lander; Benjamin Gitlitz, Thermopolis; F. H. Haigler, Casper.

Cancer Committee: Joseph A. Gautsch, Chairman, 1956, Cody; Karl Krueger, 1954, Rock Springs; John Gramlich, 1955, Cheyenne; Dan B. Greer, 1954, Cheyenne; Franklin D. Yoder, 1954, Cheyenne; Charles R. Lowe, 1956, Casper.

Mental Health Committee: Don W. Herrold, Chairman, Cheyenne; Joseph Whalen, Evanston; Benjamin Gitlitz, Thermopolis; William E. Rosene, Wheatland.

Fracture and Industrial Health: Paul J. Preston, Chairman, Cheyenne; H. B. Anderson, Casper; J. S. Hellewell, Evanston.

Rural Health Committee: W. Andrew Bunten, Chairman, Cheyenne; E. F. Noyes, Dixon; O. L. Treloar, Afton; J. E. Hoadley, Gillette.

Gottsche Estate: Franklin D. Yoder, Chairman, Cheyenne; E. W. Gardner, Douglas; O. K. Scott, Casper; Nels Vicklund, Thermopolis; L. H. Wilmoth, Lander; Karl Krueger, Rock Springs.

Advisory to the Easter Seals Committee: Gordon Whiston, Chairman, Casper; O. K. Scott, Casper; S. S. Zuckerman, Cheyenne; J. A. Gautsch, Cody; David Flett, Cheyenne.

Poliomyelitis Committee: L. J. Cohen, Chairman, Cheyenne; O. K. Scott, Casper; Franklin D. Yoder, Cheyenne; Harlan B. Anderson, Casper.

Credentials Committee: Royce D. Tebbet, Chairman, Casper; Curtis L. Rogers, Sheridan; Nels Vicklund, Thermopolis.

Time and Place Committee: B. J. Sullivan, Chairman, Cheyenne; Chairman of Delegation from Northwestern Society; Chairman of Delegation from Natrona County; Chairman of Delegation from Sweetwater County; Chairman of Delegation from Goshen County.

Resolutions Committee: Chairman of the Council, Chairman; Chairman of the Delegation from Laramie County; Chairman of the Delegation from Uinta County; Chairman of the Delegation from Northeastern Society; Chairman of the Delegation from Sheridan County.

Nominating Committee: President, Chairman; Past Presidents; Chairman of Delegation from Albany County; Chairman of the Delegation from Carbon County; Chairman of the Delegation from Converse County.

COLORADO HOSPITAL ASSOCIATION

OFFICERS

President: Mr. Elton A. Reese, Alamosa Community Hospital, Alamosa.

President-Elect: To be appointed.

Vice President: Mr. Charles K. LeVine, Beth Israel Hospital, Denver.

Treasurer: M. A. Moritz, Denver General Hospital, Denver.

Acting Executive Secretary: R. A. Pontow, University of Colorado Medical Center, Denver.

Trustees: DeMoss Taliaferro, Children's Hospital, Denver (1954); C. Franklin Fielden, Jr., Memorial Hospital, Colorado Springs (1954); to be appointed (1954); Henry H. Hill, Weld County Hospital, Greeley (1955); John Peterson, Larimer County Hospital, Ft. Collins (1955); Hubert Hughes, General Rose Memorial Hospital, Denver (1955); R. A. Pontow, University of Colorado Medical Center, Denver (1956); Roy Prangley, St. Luke's Hospital, Denver (1956); Msgr. John R. Mulroy, Catholic Charities, 1665 Grant, Denver (1956).

COMMITTEES FOR 1954

Auditing: Paul A. Tadlock, Chairman, University of Colorado Medical Center, Denver; C. E. Buscher, St. Francis Hospital, Colorado Springs; Kenneth Rindflesh, Denver General Hospital, Denver.

Legislative: Louis Liswood, Chairman, National Jewish Hospital, Denver; Hubert Hughes, General Rose Memorial Hospital, Denver; Monsignor John Mulroy, Catholic Charities, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Roy Anderson, Presbyterian Hospital, Denver.

Membership: Daniel Ryan, Chairman, St. Joseph's Hospital, Denver; David G. Hutchison, Boulder County Hospital, Boulder; M. A. Moritz, Denver General Hospital, Denver.

Nominating: Louis Liswood, Chairman, National Jewish Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Monsignor John Mulroy, Catholic Charities, Denver.

Nursing: Roy Anderson, Chairman, Presbyterian Hospital, Denver; Dorothy E. Fisher, University of Colorado Medical Center, Denver; Sister Ascella, St. Joseph's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; W. J. Dye, Mennonite Hospital and Sanitarium, La Junta.

SPECIAL COMMITTEES

Rates and Charges: DeMoss Taliaferro, Chairman, Children's Hospital, Denver; Monsignor John Mulroy, Catholic Charities, Denver; Roy Prangley, St. Luke's Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Daniel Ryan, St. Joseph's Hospital, Denver; Elton A. Reese, Alamosa Community Hospital, Alamosa; Roy R. Anderson, Presbyterian Hospital, Denver; Hubert Hughes, General Rose Memorial Hospital, Denver; C. F. Fielden, Jr., Memorial Hospital, Colorado Springs.

Resolutions: James Taylor, Chairman, General Rose Memorial Hospital, Denver; James Henderson, Presbyterian Hospital, Denver.

Public Relations: Charles K. LeVine, Chairman, Beth Israel Hospital, Denver; Harley E. Rice, Porter Sanitarium and Hospital, Denver; C. F. Fielden, Jr., Memorial Hospital, Colorado Springs.

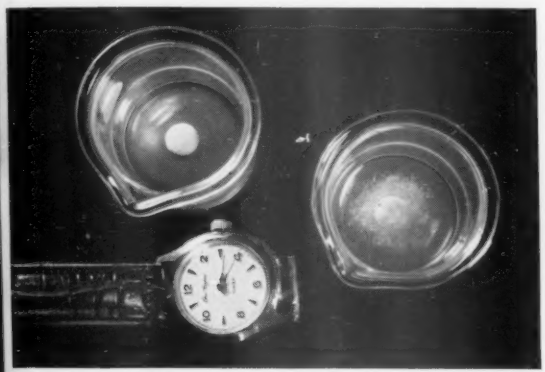
here's why your patient gets

3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new FILMTAB® ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

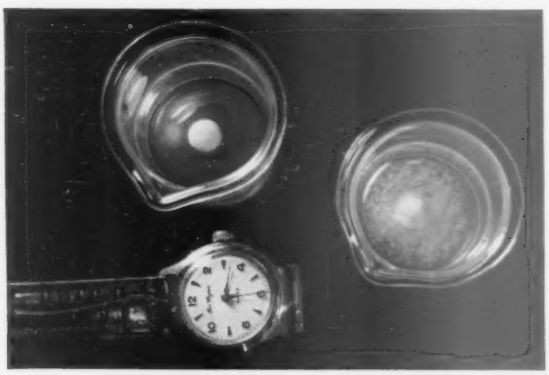
Earlier Blood Levels *from*

filmtab* ERYTHROCIN®

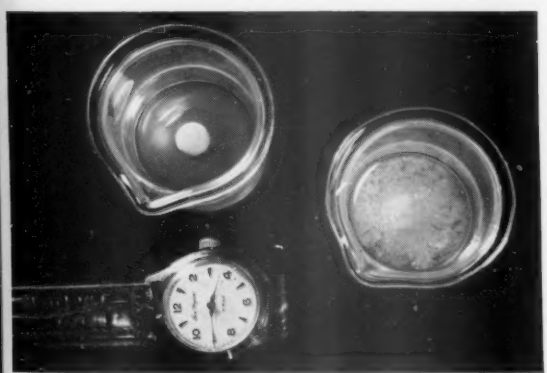
- DISINTEGRATES FASTER THAN ENTERIC COATING
- HIGH BLOOD CONCENTRATIONS WITHIN 2 HOURS



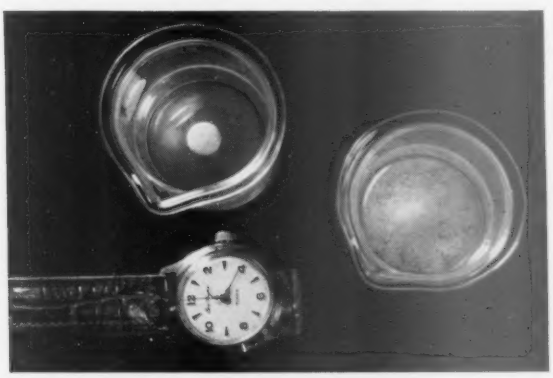
3:20—Five minutes later, *Filmtab** coating has already started to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.



3:30—*Filmtab** is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to other antibiotics.



3:45—Now the *Filmtab** tablet mushrooms out with all of the drug available for absorption. Note that enteric-coated tablet is still intact. Tests show that the new Stearate form definitely protects ERYTHROCIN against gastric acids.



4:00—Because of *Filmtab** (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear *in less than 2 hours* (instead of 4-6 hours as before). Abbott

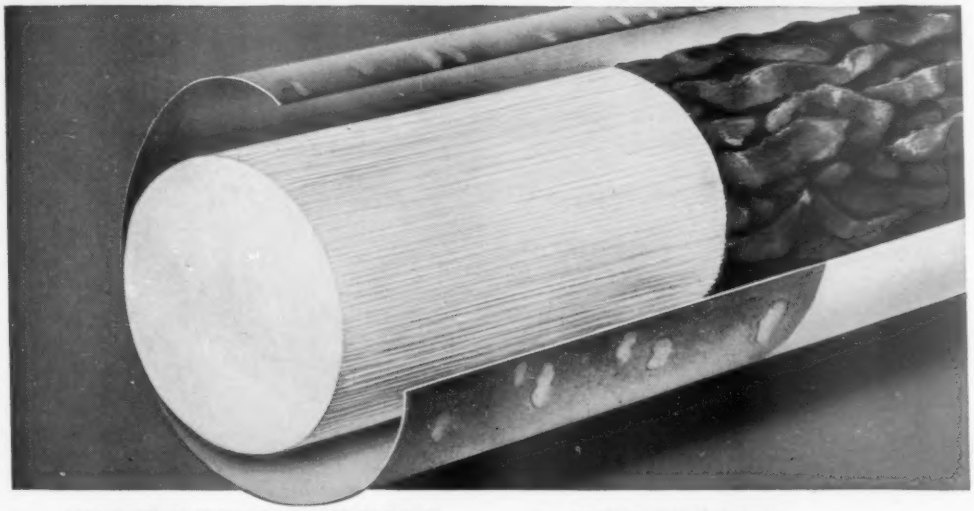
*TM for Abbott's film sealed tablets, pat. applied for.

407150

Thank You, Doctor!

To the 64,985 doctors who have visited Viceroy exhibits at medical conventions . . . and to the leaders in the medical profession who smoke and recommend Viceroy Filter Tip Cigarettes . . . we'd like to say "Thanks." Your approval of Viceroy has helped establish its leadership . . . *Viceroy now outsells all other filter tip cigarettes!*

NEW VICEROY GIVES SMOKERS
DOUBLE THE FILTERING ACTION!



1. NEW AMAZING FILTER OF ESTRON MATERIAL
20,000 tiny filter elements in this new-type filter tip, exclusive with VICEROY! Made of Estron—a pure, white cellulose acetate—this non-mineral filter represents the latest development in twenty years of Brown & Williamson filter research. It gives the greatest filtering action possible without impairing flavor or impeding the flow of smoke.

2. PLUS KING-SIZE LENGTH
The smoke is also filtered through Viceroy's extra length of rich, costly tobaccos. Thus Viceroy actually gives smokers *double the filtering action* . . . to double the pleasure and contentment of *tobacco at its best!*

ONLY A PENNY OR TWO MORE
THAN CIGARETTES WITHOUT FILTERS

New King-Size
Filter Tip VICEROY

OUTSELLS ALL OTHER FILTER TIP CIGARETTES COMBINED

Rocky Mountain Medical Journal

JULY, 1954

Colorado - Montana - New Mexico
Utah - Wyoming

EVERY doctor of medicine in the Rocky Mountain region knows Harvey Sethman, Executive Secretary of the Colorado State Medical Society and Managing Editor of the Rocky Mountain Medical Journal. Mr. Sethman has recently finished his first quarter century of service to our profession at every level, county to national, laboring with honor and distinction to himself and to us throughout all these years. There is only one other full-time lay executive secretary of a state medical society who has served continuously in that position for twenty-five or more years—Clyde Foley of Oregon. Thus, it is fitting we should pay tribute to Harvey Sethman at this time, reviewing some of his activities and enumerating a few accomplishments which have brought honor to the medical profession regionally and nationally. A Biblical quotation says, "A prophet is not without honor, save in his own country." Let us not be guilty of failing to recognize merit where it exists and pay a tribute where credit belongs!

Quarter Century Of Service

Mr. Sethman was engaged in April, 1929, to become Executive Secretary on June 1 of that year. He was assigned, by way of preparation, to study at A.M.A. headquarters and in the offices of the state societies which had pioneered in employing full-time lay secretaries—Wisconsin, Indiana and Ohio—and in Pennsylvania and Missouri which then had full-time medical secretaries. A new and challenging field in the West was opening up, and Mr. Sethman was preparing to grow up with it. Evolution of the story may be gleaned from issues of this Journal since 1929, from Minutes of the Boards of Trustees, and from physicians who have led medical organizational activities in the nation throughout the years. In the Executive Secretary's Report to the House of Delegates in 1929, he stated, "You have entrusted me with the growth of organized medicine in Colorado as represented by your Society, with the expansion of your activities that tend to advance the science of medicine and promote public health, with the widening of your influence and usefulness as an organization. I look upon the position as an opportunity to do worthwhile things coincidentally with earning one's living, an opportunity to be of real service to the greatest of the professions, an opportunity to help place the profession in its proper high place in the estimation of the lay public." A year later, the Society's satisfaction is summarized by a sentence from the report of its Constitutional Secretary, the late Dr. F. B. Stephenson, "I have nothing to report that will not be covered in the report of that thorough and energetic young man, whom I commend to you as my official offspring." At the same time President William Senger in his report stated, "During the past year our Society has made, I feel, considerable progress. Much of the credit for this gain rightfully belongs to our new experiment—the Executive Secretary. Those in close touch with his efforts realize that his appointment has been a most happy one.

He has built up our Society and has cemented it; he has had our committees working hard and in harmony; his diligence has made Colorado Medicine self-supporting; his other duties have been performed well. He deserves our sincere commendation." Time has proved that confidence was well founded and wise. It still persists and has grown with the years. Space will not permit mention of more than a few of his activities and marks of distinctive service.

In 1937 he was elected as the first and only lay member of the Denver Physicians and Surgeons Club, which was the oldest medical club in Denver. In the late 1930's he served two years as President of that same club. Following World War II that club merged with the Clinical Review Club of Denver, under the new name Medical Review Club, and Mr. Sethman was made an honorary life member. He was the second Secretary-Treasurer of the Conference of Presidents and other Officers of State Medical Associations and served two years, 1945 to 1947.

He is also a member and Past President, 1951-1952, of the Medical Societies Executive Conference, the national organization of salaried medical and lay executives of county and state societies of the A.M.A. He was awarded a Congressional Selective Service Medal by the President of the United States for his work in helping organize the Procurement and Assignment service for physicians in Colorado during the 1940 defense program. Until he went into the Army during World War II he was secretary of Procurement and Assignment service for Colorado and Secretary of the Medical Advisory Board for the Selective Service System. Serving as Captain and finally Major in the Medical Administrative Corps during World War II he was recently discharged from the Army Reserve Corps as Lieutenant Colonel in the Medical Service Corps.

Two years ago, on nomination by executives of the A.M.A., he was elected to membership in the Public Relations Society of America, an honor held by only a handful of medical executives in the nation.

Recognition of Mr. Sethman's ability to plan and organize progressive medical society activities has been demonstrated repeatedly in many parts of the country. He was, for example, selected to study and survey the Iowa Society's committee structure when they were seeking reorganization, and after that survey was completed, at Iowa's request, rewrote their Constitution and By-Laws which were later adopted. Many other state societies have called for his assistance in revisions of their By-Laws, particularly when they wished to copy or adapt Colorado's Board of Supervisor's system or some other idea in which Colorado had pioneered or been successful. He has been guest speaker before all of the state societies of this Rocky Mountain region and in many others more remote. Popular subjects he has discussed included, as long ago as 1940, the problem of "Modernizing Medical Public Relations," the latter of particular importance in recent much-publicized and controversial matters before the public eye. Colorado's own very recent problems in medical public relations would, we believe, have been lessened had those in charge of the issues turned for counsel to this pioneer in the field to hear and heed the voice of experience—but in this instance the Biblical quotation already referred to was all too true.

Perhaps the most outstanding local recognition Mr. Sethman has received came in 1948, when the University of Colorado on nomination by its medical faculty awarded him the University's annual gold medal "For Distinguished Public Service", in appreciation of his development of public service and public relations programs for the profession and his expansion of medical publication—mostly this Journal.

Growth and modernization of our own Rocky Mountain Medical Journal are largely the result of his imagination and hard work. The Board of Trustees of the A.M.A. made him a member in 1951 of its then just formed Public Relations Advisory Committee which suggests policies and technics for meeting problems of national scope and importance. Mr. Sethman was elected the first chairman of that A.M.A. committee and is still a

member. Since World War II he has been one of two Colorado delegates—the other being Dr. Bradford Murphey—and member of the Board of Directors of the United Public Health League, formed of eleven Rocky Mountain and western states for the purpose of opening an office in Washington, D. C., which could keep these states informed of what goes on in Congress of interest to our profession. It was active for several years until the A.M.A. Washington office was established.

Physicians in this section of America will be interested to review briefly the history of this Journal and its growth into its present form. It was originally "Colorado Medicine." Wyoming joined it in 1926, still under title of "Colorado Medicine" and carrying a sub-title "Incorporating a Wyoming section." The Rocky Mountain Medical Conference, which Dr. George Lingenfelter with the help of Mr. Sethman founded in 1935, and which originally consisted of just Colorado, Wyoming and Utah, was perhaps responsible for demonstrating to Utah the value of a joint journal. When Utah requested that it join our Journal they asked that the title be changed to something more representative of the area. Utah joined us in 1937, and the title was officially changed effective with the January, 1938, issue. New Mexico joined us in 1944, having never owned a journal; they had been subscribers to a commercially published journal, which due to the exigencies of the war suspended publication in 1944. Montana had similarly subscribed to a commercial journal, and joined our Journal in the fall of 1947. The success of the Rocky Mountain Medical Conference as a biennial interstate meeting was certainly partly responsible for this development of our Journal. The Rocky Mountain Medical Conference originally consisted of Colorado, Utah and Wyoming, but New Mexico joined it in 1939, and Montana joined in 1941. Its membership, and the participating states in the Journal, are now identical.

The Board of Supervisors of the Colorado State Medical Society was an outgrowth of the Raymond Rich survey on public relations. The original suggestion came from Raymond Rich Associates, but the implementation of it was modified by Colorado's House of Delegates. Once established, it attracted national attention and was soon copied by many other states. Eventually, on urging by the Kentucky Medical Association, which had had a good deal of correspondence with Colorado on "how we did it", the Kentucky Association sponsored and put through the House a resolution whereby the A.M.A. urged that every state establish such a system. Mr. Sethman was very active in making the system work in Colorado and, after it began to attract such attention, he was invited to talk on it before many state societies and before the Conference of State Society Secretaries and Journal Editors at its biennial meeting at the A.M.A. in Chicago.

The New York Times had written a long article about Colorado's Board of Supervisors. This came to the attention of people who ran a weekly panel program on which they invited Mr. Sethman as their guest panelist on a one-hour program over the N.B.C. hookup. The Board of Supervisors was discussed on that program as one of the items of nation-wide interest.

As part of a tribute to Harvey Sethman on his twenty-fifth anniversary, Dr. Claude Bonham, President of the Colorado State Medical Society, received over one hundred letters of commendation on his behalf from friends in all parts of the country. We will quote part of one from Dr. Edward J. McCormick, President of the American Medical Association:

> I have been advised that Harvey Sethman will soon complete twenty-five years of service as Executive Secretary of the Colorado State Medical Society. I have had many conferences with Harvey Sethman and I feel that he is one of the best Executive Secretaries in the United States. He knows his job and is fearless. He is a man of fine character and is honest and devoted. There is no question in my mind that Harvey Sethman could probably better himself if he so desired. However, he is a dedicated individual and Colorado is extremely fortunate in having such a fine man as its Executive Secretary and Advisor.
>
> I know of no one in the United States who does not respect Harvey Sethman and his views, al-

though in some instances they may not agree with his conclusions.

Harvey has been extremely thoughtful of everyone in the medical field. He has done an outstanding job. He may not be wealthy in the sense of accumulated money, but he is extremely rich in a host of friends who appreciate what he has done.

No one, particularly one who has done so much, can always be right. However, as Mr. Sethman said in one of his earliest annual reports, "It is inconceivable that I have not made some mistakes in detail, or that I will not make mistakes in the future. Those of the past and any in the future are and will be mistakes of the mind, not of the heart. I beg the cooperation, help and advice of all of you, and particularly of the officers and the County Secretaries, to the end that my mistakes may be as few as possible." Looking back over the quarter century since those words were spoken, we believe that any mistakes have been indeed "as few as possible." And far above all, he has shone as a strong beacon with head held high in the honest fulfillment of a job he knows is important to the greatest profession on earth and the people whom we serve.

DOUGLAS W. MACOMBER, M.D.,
Scientific Editor.

The Doctor's Family Has No Family Doctor

MY DAUGHTER returned from college for her spring vacation. She mentioned a friend whom she had met during the school year, and made the remark that this girl had almost died, "because she was a doctor's daughter." I immediately asked what was meant by this statement. She said, "Because she almost died when she had her baby. She had heart trouble, and no one had examined her to determine that there was anything the matter with her. In other words, she had never had a complete examination because she was a doctor's daughter!"

As a result of this statement, inquiry has been made, locally, as to the most recent examination of wives and children of doctors in our medical community. It is sad to report that, undoubtedly, the most neglected cross section of American citizens, from a medical standpoint, is that of doctors' families. As long as a wife is able to get a meal on the table, keep one's shirts in the drawer, and otherwise move about, answer the telephone, chase one down when out on calls, etc., it is quite obvious that she is doing very well. The same situation prevails with our children.

Further inquiry reveals that doctors not only are pleased to examine another doctor's family and treat them where and when indicated, but they are honored in being requested to do so. The chief difficulty lies in the family who is being neglected. They are loath to impose themselves upon another doctor, because they feel that they are taking up time that should be allotted to someone who probably pays his bills.

It would appear to me that the only answer to this type of situation is that we become more realistic in our attitude, that we call our colleagues in the next few days, and request that an appointment be given to our wives and families for routine examination. I, for one, know I was a blood type AB for years, because I was typed in the Army. It was only last week that I finally had enough courage to have my finger stuck, and learned that I am type AB Rh Positive. On inquiry among my colleagues, I find that most of the doctors who know what their types are, know so because they were in the service and have no fractional knowledge of their types beyond the initial. Perhaps we are the exception to the rule, but I doubt it. Also, it wouldn't be a bad idea to have the doctor checked, too. By the way, Doctor, when were you checked last?

We feel that charity begins at home, and I am sure that medical attention should begin at the same place.

J.W.S.

Housewives' Eczema*

Denver
HENRY M. LEWIS, M.D.

ERUPTIONS upon housewives' hands are among the most common skin disorders seen in the physician's office. For many years, treatment of these distressing and often chronic cases of hand dermatitis was beset with empiricism; improvement or aggravation would occur for no apparent reason and a classification of causative factors remained a highly desirable but unachieveable goal. Today the picture has changed. The therapeutic frustration once associated with these cases has been largely dispelled by recent advances in our knowledge of cutaneous physiology, so we can now approach this subject on a more logical, more scientific, and more predictable basis.

Because the etiologic approach to management of any disease gives most promise of success, we shall consider first the predisposing factors, follow with a discussion of the existing agents and their synergistic interplay, then conclude with therapeutic suggestions.

Predisposing Factors

Heredity and Constitution: Consider the blue-eyed, thin-skinned, light-complexioned woman. She has a "sentitive" skin, notable for its allergic inclinations and its susceptibility to innumerable endogenous and exogenous damaging agents.

Nervous Stress: Both laboratory and clinical experience strongly suggests that mental turbulence increases greatly the cutaneous susceptibility to allergens and primary irritants. Emotional tension increases the outpouring of palmar sweat. When this is combined with plugging of the sweat duct orifices, the picture of pompholyx results and may lead to a true exudative neurodermatitis. The overconscientious, tense, restless woman who is preoccupied with cleanliness, routine, and order suffers a greater incidence of hand dermatitis than her more phlegmatic sisters.

Exciting Factors

Soap and Water: These are the most common applications to the skin. Although soap and other detergents are considered by the laiety to be the cause of most hand eruptions, we must keep in mind that water, and water alone, is probably enough to account for the difficulty. Immersion of the hands in water, with insufficient drying, produces "chapping" of the skin. The horny protective surface of the skin becomes hydrated, loses its elasticity and is easily fractured. One sees this commonly over the knuckles, an area under constant tension from flexing the fingers.

These same factors operate at the usual site of onset of housewives' eczema, the ring finger base. Here there is a space beneath the jewels of the wedding and engagement rings which accumulates soap, water and other household debris over a period of months. This area of skin remains wet when the remainder of the skin is dried. Constant friction of this wet mass against the skin produces irritation and provides a source from which the hand dermatitis spreads.

Sweat Duct Occlusion: The importance of sweat duct plugging in the production of housewives' eczema is so great that one is justified in elaborating on this subject. When heat intolerance in soldiers prompted research into the physiopathology of the sweat gland apparatus, an entire new era of dermatologic thought was laid open. The sweat duct, as it passes through the epidermis, has no cellular lining. Therefore, edema

* Presented before the Colorado State Medical Society, Denver, October 2, 1953.

of the epidermis as a result of internal or external stimuli, or hydration of keration, may produce closure of the sweat pore and plugging of the distal portion of the sweat duct. Of course, the gland continues to secrete, often at an increased rate if emotional stress is present. This results in distension and often rupture of the duct in the epidermis. Blister formation (vesiculation) follows and is accompanied by itching when the sweat, being unable to discharge onto the surface of the skin, escapes into the surrounding tissues.

Many women with hand dermatitis will wear rubber gloves to protect their hands. We are all familiar, as doctors, with the increased sweating produced by the rubber glove and can readily comprehend that this device, in contact with the skin, serves only to aggravate the eruption.

Household Chemicals: In her daily chores, the housewife comes into contact with many skin-damaging chemicals. Disinfectants, polishes, insect sprays, steel wool, ammonia, bleaches, utensils and wall cleaners are but a few of these. And contact with tomato, celery, or citrus fruits will not be tolerated by the hand with even a small amount of dermatitis.

Contact Dermatitis: A true allergic eczematous contact dermatitis is often the primary exciting agent in housewives' eczema. The patient may become allergic to metals, rubber products, plastics of various types, houseplants and insecticides. Chemicals applied to the skin in baby oils, hair tonics, and hand lotions may be culpable; such ordinary objects as thimbles, needles, playing cards, compacts and wooden knife handles may be allergens to some women. Many therapeutic agents, including antihistamine creams, have a relatively high sensitizing index, and most of these cutaneous sensitizers have been introduced within the past fifteen years. It has been difficult indeed to keep abreast of the innumerable so-called "specific" antipuritic and antieczematous chemicals.

Bacterial Factors: In any chronic dermatitis, the normal saprophytic cutaneous flora may disappear and be replaced by pathogenic strains of staphylococci and streptococci which may add an impetiginous overlay to the pre-existing dermatitis. In addition, allergic reactions to bacterial nucleoproteins and polysaccharides may occur. These substances alone may be partial antigens, but when combined with keratin acting as a hapten, a full antigen is formed and the picture becomes that of infectious eczematoid dermatitis. Should this complication develop, the eruption becomes ever more recalcitrant to therapy and may be perpetuated long after the instigating agent has disappeared from the scene.

Food Allergy: Less often, food allergy may be an etiologic agent in housewives' eczema. Sulzberger offers the thought provoking hypothesis that ingested food allergens produce hand dermatitis through contact of the allergen with the epidermis when sweating occurs into, rather than onto, the skin. The food allergen would normally be excreted with the sweat. Despite efforts to simplify the identification of food allergens, in everyday practice their specific recognition is difficult indeed. Fortunately, hand dermatitis in which food allergy is the major etiologic factor is probably a rare occurrence.

Treatment

To the physician confronted with this bewildering array of etiologic components, what constitutes a simple, practical and effective therapeutic approach to the problem?

Most important by far is a detailed, painstaking, sequential history. One attempts to elicit exposures to household chemicals, to nervous upsets, to excessive use of detergents and water, to applied medications and suspicious contactual allergens. The temporal exposure relationships of these agents to each other and to aggravation of the dermatitis should be correlated. But too often the history is indefinite and clearly defined entities cannot be isolated. The housewife is then given a detailed list of therapeutic instructions.

First, complete avoidance of soap and water is mandatory. The patient is re-

quested to obtain six pairs of men's thin white cotton (pallbearer's) gloves, and to turn them inside out at the time of purchase so that the seams face outward and the smooth surface lies against the skin. She also obtains two or three pairs of plastic or rubber mittens.

Emphasis is placed on the need for complete isolation of the involved hand areas from their normal environment. No water, edibles or potential sensitizers are allowed to touch the affected skin for ten days. Whenever wetting of the hand or contact with damaging substances is anticipated, the cotton glove is drawn on, then the rubber or plastic mitt is drawn over it. The outer glove should not contact the involved skin and should be worn for short periods of time only, lest perspiration of the hand become too pronounced. Often the cotton glove is worn alone with the uninvolved glove fingers cut off; this acts as an effective bandage during routine household chores and facilitates the handling of small objects. Most women are quite willing to undergo the small amount of discomfort this procedure entails, for it is well justified by the results obtained.

I prescribe Domeboror powders for most acute cases and recommend that one powder be dissolved in a pint of ordinary tap water, then six ice cubes added. The patient draws on a pair of cotton gloves and, using the gloves now as a compressing material, immerses the hands in the prepared solution. The hands are immediately withdrawn and held over the surface of the solution so that evaporation may take place. In a minute, when the hands no longer feel cool, they are re-immersed and again removed. This process is repeated for about three-quarters of an hour and the solution prepared fresh for compressing three times daily. Potassium permanganate 1-6000 or silver nitrate 1-400 aqueous may be employed as compressing solutions if gross infection is present, but Burow's solution prepared fresh as described will suffice for most cases.

After compressing, a thin film of the prescribed paste is applied. Three per cent ichthyol or 3 per cent vioform powder in plain Lassar's paste may be used, or one may prefer the time-honored "1-2-3" ointment. This is composed of one part Burow's solution, two parts anhydrous lanolin and three parts Lassar's paste. These salves are removed gently with warm mineral oil before re-compressing, but the patient cautioned that if the salve does not come off easily, she is to compress over it.

Compresses, hand isolation and soothing pastes usually suffice to bring the eruption under control. Should there be no improvement after the first office visit, the patient is asked to confess how much "cheating" she has done. This is important, for even one exposure to tomato in the preparation of a salad may vitiate the benefits derived from two days of therapy. The patient is urged to adhere conscientiously to the outlined regime.

Hydrocortisone ointment will help some, but by no means all resistant cases, and I have seen several instances of aggravation following its use. X-ray therapy, under the guidance of a dermatologist, will relieve itching and diminish lichenification of the skin in most instances, but this is a procedure for the specialist.

Cortisone and ACTH have value in getting the patient "over the hump," but the use of these potent steroids is fraught with danger. Moreover, cortisone and ACTH may interfere with normal antibody formation and the patient may suffer a disappointing relapse after their use is discontinued. For severe, intractable cases, the employment of these drugs may be warranted for a short time, but for routine use they are mentioned only to be condemned.

If the hand dermatitis persists or is aggravated despite the measures outlined, referral of the patient to a dermatologist will often save her time and money, for the dermatologist has devoted a great deal of time to the study of this problem and has many additional investigative and therapeutic tools available.

In the six months since ACHROMYCIN was first announced** at the Antibiotics Symposium of the Food & Drug Administration, this new broad-spectrum antibiotic has become a major weapon in modern medicine.

ACHROMYCIN has demonstrated notable effectiveness in a wide variety of clinical applications and the following characteristics are outstanding:

ACHROMYCIN is effective against pneumococci, staphylococci, beta hemolytic streptococci, gonococci, meningococci, *E. coli* infections, acute bronchitis and bronchiolitis and certain mixed infections.

ACHROMYCIN has definitely fewer side-reactions than certain other broad-spectrum antibiotics.

ACHROMYCIN provides prompt diffusion in body tissues and fluids.

ACHROMYCIN *in solution* maintains effective potency for a full 24-hours.

ACHRO

HYDROCHLORIDE
TETRACYCLINE HCl LEDERLE

proved effective against

Pneumococci | Staphylococci | Beta Hemolytic Streptococci | Gonococci | Meningococci | *E. coli*

NOW AVAILABLE:

CAPSULES: 250 mg., 100 mg., 50 mg.

SPERSOIDS*: 50 mg. per teaspoonful (3.0 Gm.)
Dispersible Powder

INTRAVENOUS: 500 mg., 250 mg., and 100 mg.

Other dosage forms are being developed as rapidly as research permits.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

Lederle

*REG. U.S. PAT. OFF. **CUNNINGHAM, R., HINES, J.: LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY


MYCIN*

*Presidential Address**

JOHN F. CONWAY, M.D.
Clovis, New Mexico

I AM, of course, deeply appreciative of the honor of being chosen as your President for the coming year, but considerably awed by the volume and importance of the work which must be done. The past year has offered an opportunity to gain familiarity with our problems by observing the activities of your officers in their efforts to carry on the business of the State Society in an effective way. At the same time that I pledge the best of which I am capable during the coming year it must be emphasized that sincere interest, willingness to work, and whole-hearted support from a great majority of the members of this Society are essential factors in the making of a satisfactory year for New Mexico medicine.

Committees composed of men who are capable and enthusiastic have been appointed. We want them to feel free to seek the help and guidance of the Council in carrying out their work. It is requested that they make a brief report of their activities to the Council by October 10 and again by January 10 for its information. By those dates there should be some evidence of progress or obstacles requiring a revamping of their program should be apparent. There are very definite problems for the attention of each of these committees to which in addition other matters as they arise will be referred.

The Legislative Committee should determine the views of the membership regarding (1) the need for any legislation, (2) the type of legislation required, and (3) the extent to which members or individuals are willing to support a legislative program. It should also initiate discussion of any contemplated program with candidates for office so that they will be familiar with our problems and suggested solutions therefor. It should inform our members as to the stand taken by these candidates on problems of legitimate interest and importance to us. It should discuss such of our problems as may be of intimate concern to other groups with those groups.

It is my hope that the House of Delegates will outline general principles for the guidance of this committee. It should be allowed considerable latitude as to the exact measures which it takes in an effort to accomplish your will.

The Public Relations Committee should work closely with the Legislative Committee to assure the understanding by the profession, the public and the legislature of our legislative program. It should also acquaint itself, the profession and the public with the problems of medical care of veterans and with the views of the American Medical Association regarding this matter.

It should meet with representatives of the press and radio to work for mutual understanding of our problems, to attempt to solve these problems as previously recommended, to acquaint the members of this Society with their part in maintaining satisfactory relations with the press and radio the while being ethical in their doctor-patient relationship. The committee should initiate a program directing the attention of members to the importance of becoming more familiar with and paying more heed to the principles involved in the Code of Ethics. It should encourage doctors to take every means, including the display in offices of the plaque provided by the Ameri-

*Delivered before the Annual Meeting of the New Mexico Medical Society, Santa Fe, May 13-15, 1954.

can Medical Association for this purpose, to assure patients that services will be rendered at a reasonable cost and that discussion regarding this aspect of the patients' care is invited.

It should be suggested to members that insurance and welfare patients be seen only after verifying that a colleague who has been caring for the patient knows of the consultation, has agreed to it or has been dismissed and that reports of agreed-upon consultations be forwarded the attending physician. And, finally, this committee should publicize the activities of the profession in its attempts to render the highest type of medical service.

The Welfare Committee should serve as a body representing the New Mexico Medical Society in any dealing with agencies concerned with welfare or medical care of indigents; should continue to work out with the Department of Welfare a fee schedule for the approval of the State Society; should make arrangements to prevent the transfer of patients without the knowledge of the attending physician; should take steps to simplify necessary reports by doctors to the Welfare Department; and should consider the advisability of recommending to the Legislative Committee introduction of an "indigent support" bill to fix upon families some financial responsibility in instances where they are able to accept it, to the end that (a) the general population is not forced to assume the cost of care which should be a family responsibility and (b) the physician is not requested to accept, as purely welfare patients, those people whose families are able to pay for part or all of their care.

The Insurance Committee should handle all insurance matters except those related to our voluntary prepaid health insurance plan — the province of New Mexico Physicians Service. It should explore with the carriers of our group disability policy ways and means of increasing the length of time of payment of indemnity for sickness. At present it is limited in our Washington National policy to twenty-four months for nonconfining sickness and to sixty months for confining sickness. The Commercial Casualty policy limits payments for disability due to accident to five years. The payment of sickness indemnity is limited in this policy to fifty-two weeks. Provision should also be made for the payment of some benefits for partial disability. Efforts to obtain a group malpractice policy for the Society should be reviewed. Brief uniform insurance reporting forms should be agreed upon by companies whose claimants we see, to the end that such reports can be rendered with a minimum of paper work. In the instance where more information is required a narrative report should be accepted. Arrangements should be made with representatives of insurance companies doing business in this state to the end that (1) doctors caring for patients will be notified if consultation is desired, (2) the approval of the doctor for such consultation should be gained or he should be dismissed and (3) the doctor receives reports of consultation to which he has agreed. This committee should also concern itself with other insurance matters—excepting those regarding prepaid health insurance—as they arise.

The Advisory Committee on Selective Service, contrary to what our impression has been, is now necessary. Dr. H. L. January and Dr. George Morrison are again asked to serve on this committee. Dr. Ray Young has agreed to replace Dr. Travers, who has retired and to whom we wish to express our appreciation for past services.

The American Medical Education Foundation Committee, of which Dr. I. J. Marshall of Roswell is chairman, has been diligent and he is respectfully requested to continue it.

Dr. Michel Pijoan has done an outstanding job of research into the problems of rural health in New Mexico. His work has been published and is of great help to the State office in providing information to doctors considering locating in New Mexico. He has agreed to continue this work as chairman of our Rural Health Committee. As the need requires, other members may be asked to accept appointment to this committee to help with specific problems.

The New Mexico Physicians Service should continue the functions it has been fulfilling in providing the people of this state with a professionally sponsored and supported voluntary health plan. It should work for a more complete understanding of the plan and what it is actually doing for the public and the profession. It should provide information to members as requested regarding health insurance in general, and should call the attention of the Society to any plan which provides for professional services in the hospitalization section of the contract.

The Board of Supervisors should continue the type of work it has done in the past, and constitute a body to which ethical problems can be presented in an effort to forestall difficulties. In order to act effectively and promptly this group should meet not less often than once in two months and preferably once a month, depending on the amount of work submitted to it. Proper action should be taken by the House of Delegates to elect alternates for each delegate to ensure the presence of one from each district at all meetings. Suggested nominees for this board should become candidates only after having had an opportunity to decide whether or not they feel they can and will devote the necessary time to this very important part of the work of the profession.

That, I think, explains our present plans. If there are now or if there should appear other matters on which you feel action should be taken we shall appreciate hearing from you either as individuals or as County Societies.

Statistical Survey of Cases of Pulmonary Embolism*

CARL S. GYDESEN, M.D., GERALD H. SMITH, M.D., and JAMES W. MCMULLEN, M.D.
Colorado Springs, Colorado

DURING recent months the discussion of pulmonary embolism has occupied the attention of the staff of Glockner-Penrose Hospital at several clinico-pathologic conferences. We decided to review the case histories of the hospital and determine how many cases of pulmonary embolism have been diagnosed and also examine the results of the treatments in vogue. We, therefore, present the results of this survey which includes 29 cases observed between January, 1952, and May, 1953. This review records only the symptoms, physical signs and laboratory data as reported by the attending physician. Doctor McMullen, the roentgenologist, frequently reported a diffuse haziness of one lower lobe of the lung which occurred at an early stage of the clinical course of the syndrome. Although this has been previously described, our x-ray reports mentioned this in a strikingly frequent manner. We are bold to call your attention to our experience and stress the probable importance of this observation.

During the past five and one half years Doctor Erving Geever performed twenty-five autopsies in which pulmonary embolism was one of the final anatomical diagnoses. During the past one and one half year, twenty-nine clinical cases were observed. Of these, nine died and eight came to postmortem. During these eighteen months 7,727 patients were admitted to our hospital and the twenty-nine cases which sustained a pulmonary embolism were .4 per cent of these total admissions. There were six cases from the surgical service which was 1 per cent of the total admissions. In turn, four cases or .7 per cent were reported in orthopedic or traumatic surgical cases. As usual, the highest number of cases came from the medical service; namely nineteen cases or 1.8 per cent.

Occurring postoperatively were 36 per

*Presented before the 83rd Annual Session, Colorado State Medical Society, September 29 to October 2, 1953, in Denver, Colorado.

cent of our cases. Of these, 16 per cent followed orthopedic procedures. As in larger statistical series, the cardiac patients were the largest per cent of the series or 57 per cent. There were six of our cardiacs who underwent surgical procedures and experienced postoperative embolism. The same situation pertained with one cardiac who underwent an orthopedic operation.

In the 20-40 year age group four cases occurred while thirteen occurred in the 40-60 year group and twelve in the 60-80 year group. The sex distribution was equivocal and all nine deaths occurred between the ages of 40-80 years. When the accident occurred eighteen of our patients were at complete bedrest, while eleven were ambulatory. The surgical cases were equally divided here but more cardiacs were restricted to their beds.

In reviewing the clinical features of our cases we found that the premonitory symptoms and signs followed the usual classical descriptions. Chest pain was the commonest symptom and this usually occurred suddenly and without warning. Cough was also common. Apprehension, weakness and abdominal pains were also frequently recorded. Of the physical signs, acute dyspnea and elevated temperature were commonly recorded. Cold perspiration, tachypnoea, cyanosis and blood-tinged sputum were noted in one-third of the cases. Our records were disappointing in regard to the usual definite precipitating factors such as straining at stool, getting out of bed or out of a wheel-chair. In 24 of our cases no definite precipitating factor was recorded. This hiatus might well have been due to the excitement of the moment and the nurses neglected to make proper records.

It is now time to separate the cases which proved to have small or multiple small emboli which later produced small pulmonary infarctions from the dramatic massive emboli which eventuated in acute cor pulmonale and sudden death. We had four of these latter cases and they all died. In the minor disturbances the apprehensive patient usually experienced a sudden pleural pain. Fever was usually recorded with tachycardia. Hemoptysis and dyspnea occurred and suppressed breath sounds and scattered rales were found. Friction rubs and enlarged neck veins were rarely recorded.

Doctor McMullen possesses some chest films which have certain signs which might be pathognomonic for small and repeated pulmonary emboli. Most of our cases were x-rayed shortly after the chest pain occurred. Doctor McMullen frequently recorded an indefinite haziness under the area of chest pain. This haziness was occasionally accompanied by an infiltration of the costovertebral angle and an increase in hilar shadow. Later, unilateral or bilateral effusions occurred and an increase in the cardiac shadow was noted. ECGs were done nine times and on one or two occasions positive findings were recorded. Our four cases of massive pulmonary embolism experienced the usual classical dramatic episode which consisted of pleural or subpleural pain which started suddenly and without any other premonitory signs. This was accompanied by dyspnea, cyanosis, pallor, sweating, weakness and fall of blood pressure. We were fortunate enough to obtain positive x-ray signs in three cases and positive ECG signs in two cases. One of these produced a right bundle branch block.

TABLE 1*
Pulmonary Embolism and Cor Pulmonale Clinical Features—Onset—Premonitory Symptoms and Signs in Twenty-nine Case Records

Symptoms:	
Sudden onset and without warning	17
Apprehension	7
Cough	13
Chest Pain	23
Weakness	6
Abdominal Pain	5
Substernal Fullness	0
Faintness	1
Mental Symptoms	3

*Glockner-Penrose, Jan., 52-May, 53.

We found that a paucity of prophylactic measures had been used on our patients. Although the presence of thrombo-embolism was recognized in nineteen cases, we found no record of the use of elastic stockings as advocated by Linton of Massachusetts General Hospital. We have no records of purposeful early ambulation or exercises in

bed. On two occasions anticoagulants and heat cradles were used preoperatively. The physicians were alert in recognizing the signs of venous thrombosis such as Homan's sign, edema, enlargements of the calf and calf tenderness as well as femoral tenderness. In fourteen cases anticoagulants were used before the embolism occurred and in one case venous ligation was performed, also one sympathectomy was done with good results. One venous stripping was recorded. Our treatment seemed to follow a definite pattern in that sedation and anticoagulants were used freely. Half of the cases received oxygen but intravenous atropine was not used. Papaverine was used intravenously four times. Nerve block for pain was done once with good results. No one attempted surgical removal of pulmonary embolus.

TABLE 2*
Pulmonary Embolism and Cor Pulmonale Clinical Features—Onset—Premonitory Symptoms and Signs in Twenty-nine Case Records.

Signs:	
Cold Perspiration	8
Acute Dyspnea	18
Tachypnoea	9
Cyanosis	8
Hemoptysis	7
Convulsions	1
Increased Temperature	19
Paroxysmal Arrhythmia	2
Sputum	
Clear	4
Blood Tinged	9
Distension of Neck Veins	1

*Glockner-Penrose, Jan., 52-May, 53.

In twenty-nine cases we had nine deaths and we obtained eight postmortems. Of these cases twenty-four experienced simple attacks and four experienced two attacks and two cases had multiple attacks. No abscess formation was found on our postmortem series.

Summary

A statistical review of twenty-nine cases of pulmonary embolism and cor pulmonale which were treated in Glockner-Penrose Hospital from January, 1952, to May, 1953. Several chest films show a diffuse haziness which preceded the episode of pulmonary embolism and this might be of prognostic value.

Decreased Pain Sensitivity And Its Dangers*

MEYER A. RABINOWITZ, M.D.
Brooklyn, N. Y.

CLINICAL aspects of disease as described in textbooks are usually those found in patients sensitive to pain. Under the tutelage of that eminent clinician, Dr. Emanuel Libman, I learned that in people hyposensitive to pain, the clinical picture may be at great variance from the one usually expected. To determine sensitivity or its lack, the Libman "styloid pressure test" was used. A large number of our diagnostic difficulties occur in patients belonging to this hyposensitive group. Were the test made on all hospital patients, I suspect that many of the cases pounced upon by the pathologist for clinical-pathological conferences, to the discomfiture of the discussants, would fall in this group.

*Presented before the Rocky Mountain Medical Conference, Sept. 10-12, 1953, in Salt Lake City.

Before describing the "styloid pressure test", let me briefly cite a case reported in the British Medical Journal of August 6, 1932, page 241. A retired schoolmaster, aged 70, was sitting at a table in a public library, writing, when he collapsed to the floor and died almost instantly. Careful inquiry among his wife, relatives, and friends failed to suggest that he had any symptoms or had thought that he was ill before the fatal seizure. Moreover, he had never been known to have been ill or to have received professional attention. He had never complained of any pain. He did not seem to have had any difficulty over the two flights of stairs leading to the library, nor to have been short of breath. The postmortem examination re-

vealed widespread, severe coronary atherosclerosis, an old thrombus in the left circumflex branch, rupture of a thinned out aneurysm on the posterior surface of the left ventricle, and an ounce of blood clot in the pericardium. The pathologist concluded "it is probable that some months at least must have elapsed between the initial thrombosis and the fatal termination. When one considers the profound general illness usually associated with the condition, it is surprising that a man and his friends should be entirely ignorant that anything serious was amiss." Yet one of his friends later stated that he thought that the deceased had looked older and grayer lately. From this we may assume that he had that "earthy hue with leaden overcast" found in patients with old coronary closure.

For the practical purposes of the general practitioner, who is the patient's first line of defense, we need no elaborate or cumbersome instrument to determine sensitivity. The technic of the Libman test is simple and takes but a few seconds. My first step in the recording of the physical examination of a patient is a notation minus or plus according to whether the test reveals that he is hyposensitive or sensitive. Press the thumb against the tip of the mastoid process, which serves as a control unless diseased, because it is normally non-sensitive. Then slip the thumb forward and push against the styloid process, avoiding the ramus of the mandible. In case of doubt, check the other side, and classify the patient according to the lesser sensitivity found. If doubt still exists, repeat the test a little later. One can readily familiarize himself with its technic and learn to evaluate the reaction of the patient to the test. The sensitives are those who give physical or vocal evidence of being hurt, or those who, controlling these expressions of pain, on being questioned, admit that they felt marked pain. All others are classified as hyposensitive. They give little or no evidence of being hurt, and when asked, "does it hurt where I press?" answer that they feel no or little pain or only pressure. The value of the test may be obscured by the recent use of narcotics or analgesics.

While some hyposensitives react to disease like sensitives, and some sensitives react like hyposensitives, the hyposensitive is more likely to react to disease in a manner at marked variance with the textbook picture. He may have little or no pain, or instead of pain, talk of such sensations as boring, coldness, crowding, cutting, discomfort, distension, distress, fullness, heaviness, itching, numbness, pressure, tingling, or weakness. Moreover, he may localize his pain or sensations to an area remote from or on the opposite side to the disease process, or give inverse radiations of pain.

As substitutes for pain he may have symptoms referable to the central nervous system, or by way of the autonomic nervous system to the cardiovascular, respiratory, or digestive organs. Such symptoms are especially complained of in heart and abdominal diseases, and in the absence of pain, are of great diagnostic significance.

Symptoms referable to the nervous system may be numbness, depression, psychotic behavior, headache, sleeplessness, dizziness, tremor, faintness, syncope, collapse, profuse sweating, and general or local weakness. The facies may exhibit anxiety or fear. (Illustrative cases: psychotic behavior in cancer of the pancreas; migrainous headache in cancer of the gallbladder; dizziness in coronary disease and gallbladder disease; syncope in gallstone attack; collapse in acute coronary closure, and in old coronary closure during an attack of acute appendicitis; generalized weakness in cancer.)

Cardiac disturbances such as extrasystoles, tachycardia, auricular fibrillation, or heart block may substitute for pain in abdominal conditions. (Illustrative cases: tachycardia in young female postoperatively; heart block with Stokes-Adams attacks in gallstone disease.)

Metabolic disturbances such as glycosuria and hyperglycemia occur in coronary thrombosis in the non-diabetic.

Disturbances in the digestive tract such as aerophagia, belching, nausea, vomiting, indigestion, gas, constipation, pains referred to different areas of the abdomen, and bowel urgency are the results of reflex spasm of the cardia, pylorus, ileocecal junction, splenic flexure, or sigmoid flexure. (Illus-

trative cases: nausea and vomiting in coronary occlusion leading to erroneous diagnosis of acute abdomen; a patient with "silent" cardiac aneurysm who on close questioning admitted to a short attack of indigestion some months ago; bowel urgency at onset of coronary thrombosis and in ureter colic; ileocecal spasm in gallstone attack erroneously diagnosed appendicitis; spasm of sigmoid in duodenal ulcer and left ureter calculus.)

Respiratory tract manifestations include sneezing, yawning, coughing, choking, and dyspnea. (Illustrative cases: dyspnea in absence of myocardial infarction, dyspnea instead of pain in acute coronary occlusion, choking sensation in acute coronary occlusion.)

When several diseases are simultaneously present in a hyposensitive, the more severe pain may obscure the lesser until the former is relieved. (Illustrative cases: gallbladder disease and cancer of the stomach; gallbladder disease and cancer of the sigmoid; hypertension headache and cancer of the breast; hypertension headache and cancer of the rectum; migraine headache and cancer of the gallbladder; renal calculus and gallstones; cancer of the breast and cancer of the stomach; subacromial bursitis associated with coronary disease presenting shoulder pain without precordial pain on exertion.)

The taking of a detailed history and direct leading questions are necessary in the hyposensitive because not only is he likely to have fewer symptoms, but also to pay less attention to them and even to forget them. As a result he not infrequently first comes under observation with an advanced state of the disease, particularly in the case of cancer. (Illustrative cases: jaundice in metastatic cancer of the liver; hemorrhage in peptic ulcer, and cancer of the stomach, cecum, sigmoid, and rectum; perforation of peptic ulcer in stomach cancer, and sigmoid cancer; distended cecum in sigmoid cancer and rectal cancer; pyloric obstruction in cancer of the stomach and duodenal ulcer; painless hematuria in cancer of the urinary tract; large metastatic liver in acute lobar pneumonia; large abdomen due to ascites from cancerous peritonitis of ovarian origin; thrombophlebitis in cancer of the pancreas; embolism of aorta bifurcation from left ventricular thrombus; ankle osteoarthropathy in cancer of the lung; sudden death from acute coronary closure especially after a large meal, in auto, doctor's office, revolving door, theatre during singing of the "Star Spangled Banner", golf course, and in bed; women losing their babies in street cars, department stores, and toilet bowls.)

Atypical pain sites. Pain may be felt only in a referred area. (Illustrative cases: lower jaw or left elbow pain in acute coronary thrombosis; shoulder pain in gallbladder disease or ruptured ectopic pregnancy.) The pain may be felt in an unusual site. (Illustrative cases: left iliac fossa pain in duodenal ulcer, acute appendicitis, or renal calculus; pain in left upper abdomen to left inner arm, and across to right chest in a case of acute coronary thrombosis; pain in the region of the coccyx shooting up to skull in subarachnoid hemorrhage.)

Great difficulty in diagnosis is occasionally encountered in finding the cause of fevers in hyposensitives. (Illustrative cases: otitis media, liver abscess, dental abscess, meningococcus meningitis, erysipelas scalp and lower extremity, perinephritis abscess secondary to cortical abscess of the kidney; recurrent fever and diarrhea in acute appendicitis.)

In conclusion let me state that in the hyposensitive no complaint, no matter how slight, is to be taken lightly, especially when the doctor suspects coronary or intraabdominal disease since a serious condition may exist with slight pain. Whenever possible, it is therefore best to avoid excessive sedation until the diagnosis is established. Large doses of analgesics and narcotics often lead to what might best be called "the stage of the fool's paradise", during which time perforation of a gangrenous appendix, gangrenous gallbladder, peptic ulcer, or carcinoma of the digestive tract may occur. For the same reason it is best to avoid cathartics whenever the possibility of perforation of the appendix or intestinal tract may occur.

Direct and leading questions are often

necessary to discover that the patient has been sick for a longer period than stated, and to uncover symptoms that the patient has forgotten or not mentioned because he thought them unimportant. Adequate physical examination of the entire body, including all available orifices is absolutely essential. Systematically done, it should take only a few minutes. In examining the hyposensitive patient for tenderness, it is necessary to ask not only "Does it hurt where I press?" but also, "Do you have pain or any discomfort elsewhere than where I press?" The reproduction of the patient's complaints is a most valuable clue as to the site of the disease process.

It is the hyposensitive patient who often presents diagnostic difficulties and therefore most likely to need x-ray, electrocardiogram, and other diagnostic procedures. Often hospital observation may be necessary to arrive at the diagnosis. It should be explained to the patient that being hyposensitive, he should undergo checkups at regular intervals, not ignore any change in his health status, and should follow implicitly all therapeutic suggestions.

*Presidential Address**

JAMES WM. SAMPSON, M.D.
Sheridan, Wyoming

AS PRESIDENT of your Society for the past year, it is my sincere hope that what has been accomplished has been of benefit to the Society and meets with your approval.

At this time, I would like to thank those who have made my year in office possible. I am thinking primarily of my wife and my two associates, Drs. James Wild and Herrick Aldrich. For their tolerance, forebearance, and understanding I am deeply grateful. I must also thank my office force and the members of my own Sheridan County Society who have made this meeting possible, nor can I pass this opportunity to thank the officers and committeemen of the State Society, who have done a magnificent job.

This year, I have undertaken the task of informing the membership as to the functions of this Society, and I have endeavored to impress upon the various committees their great responsibility. I am sure you have noted their amazing response. Particularly, I would like to call your attention to the reports on the State Institutions and the State Department of Health. I would also like to remind you of the Veterans Administration. Under our present laws, and with our responsibility to the public, I urge your continued support and cooperation with these groups.

We endeavored this year, for the first time, to put out an information letter to the members of the Wyoming State Medical Society, which was published and placed in the mail through the good offices of our very able Executive Secretary, Mr. Arthur Abbey. Four such letters were prepared during the year.

I then developed what I have called the "Delegates' Packet," which contained the order of business of the State Society and the reports of the various committees. This was placed in the hands of the County Society Presidents one month before this meeting so that the delegates could be instructed on a local level before coming to the State Meeting.

It is my opinion that there are several matters in our State Society which will require considerable exploration and future study. I feel that the state should be divided into districts and that our Councilors should be elected by the membership

*Presented June 8, 1954, before the Fifty-first Annual Meeting of the Wyoming State Medical Society, Sheridan.

throughout these districts, not by the House of Delegates, as some of our most able men do not get to be known on a state level but are highly regarded and respected at home.

I hope we can do away with "memberships at large." I feel small counties, population-wise, should be consolidated, and every physician in organized medicine in this state should be required to be a member of a component society. He could then be represented in the House of Delegates. It is unfair that men in Lusk, Jackson, Kemmerer, Wheatland, etc., should be unrepresented in our House of Delegates. I feel the Council should meet several times during the year in various sections of the state, and help work with and for the various County Societies, for the betterment of medicine. It is my opinion that some means of equalizing the cost of committee meetings should be arranged, so that the various committees could get together oftener to help solve more of our problems and improve the practice of medicine in Wyoming.

I am not afraid of our relationship with the public, nor am I fearful of an ultimate socialization, nearly as much as I fear the division of our Society from within. So what I intend to touch upon is the relationship of doctors with doctors.

We have many areas of division among us, and we shift from one to the other with the passage of time or circumstance. We have the young and the old, the veterans and the non-veterans. The veteran group can then be divided into the subsidized and non-subsidized. We have the rural and urban, the specialist and the general man, the thin and the fat, the bald and those with hair! We can be divided into 1,000 other categories, but, please remember, these divisions are the divisions of Doctors of Medicine, who, regardless of their classification, make up our own Society. Similar groups in other states and territories make up the American Medical Association.

In our relationship of doctors with doctors, I noticed in the May 15, 1954, Journal of the American Medical Association, under "Business Practice," this statement was made: "Petty internal wrangling and professional jealousy have no place in the medical profession in which ethical considerations are foremost. No physician should make critical comments about a fellow practitioner by word of mouth or in writing, unless he is prepared to so testify in a court of law."

I think that our problem, from the standpoint of good public relations, is a harmonious relationship among ourselves.

On one point I think we should all agree. "Never believe what a patient tells you about another doctor." Patients, like physicians, are human beings, and they can distort, distend, and misrepresent many facts. For example, within the past month it was necessary to make a house call upon a patient who was having considerable distress. His wife told me he did very well as long as he took his "Rupture Pills." I immediately sensed some degree of quackery, so I asked, "Rupture Pills?" "Yes," said his wife. "Sometimes one will help and sometimes he takes two or three and they don't do very much good".

"Where did you get them?" I asked.

"Why Dr..... prescribed them two or three years ago." Dr..... is one of my close friends. The next day I jumped my friend about the "Rupture Pills," and he assured me that the designation given them by the patient's wife was one for which she was totally responsible. Some patients think tearing the hide off the last physician when a change is made puts them on our good side. It is my considered and by no means original opinion that in a short time another hide will be flayed when they try to impress their newest doctor!

It is my impression that our greatest area of division, at the present time, is that between the general practitioner and that of the specialist.

This problem has only recently developed in Wyoming. Practically speaking, prior to World War II, there were few specialists in this state outside the EENT field.

Since World War II and during the past five years there has been a noticeable trend toward specialization, and inasmuch as this is a recent development I think it fitting

and proper to explore this field and make some observations.

Wyoming is a large state geographically, and a small state in population. It is eighth in area, but only Nevada has fewer people. Our problems are unique to our type of geography. Montana, Nevada, Arizona, and to a large extent Colorado, Utah, and New Mexico have similar problems to ours. That is, we have small cities and towns which may be 40 or 100 miles apart. We know that, economically, it takes a given number of people to support a physician, so, naturally, the men who were first attracted to our state were general practitioners. It now remains to be seen if our state has developed a large enough population to support men who devote their time to only specialized skills, for which higher fees are charged, while other men still offer the same service together with the complete care of the patient, referring, of course, where indicated.

As medicine has progressed this is only natural, because one man cannot know all there is to know in the field of medicine; in fact, it is now doubtful that one man can know all there is to know in any one of the specialities into which medicine has divided itself.

Where is our field of greatest division? Probably where things hurt most is in the pocketbook.

Any new man in a community is "competition," and as one sees old patients go to him because he is a specialist, then hears of how he collected large fees which were cheerfully and gladly given (after one has carried this patient on the books for years) one is bound to be disturbed.

By and large, the specialists we have obtained in Wyoming are young men. That is only right and fair, but it is a strange paradox that the man who has the least time left in this world wants the least amount of change, whereas the younger man who has a long life time ahead of him wants changes immediately.

I think a good bit of the friction I have seen develop has developed largely due to the impetuousness of youth, and due to his high standards and his idealism all of which I think are good. Nevertheless, we must face facts: that the best changes are made through the demonstration and education for their need and usefulness, not because some person says they are good.

At this point, may I call your attention to some of our pioneer doctors and founders of this organization. Some are still available for counsel and advice, which is most valuable. I have, myself, used some of it this year. Many of our problems, new to us, have been experienced and solved by them.

A specialist improves the standards and raises the quality of medicine, if he is a good man, throughout the whole community. For example, total hysterectomies are the standard operative procedures after a Gyn man enters a community, where supracervical was the procedure of choice before. If the other men in the community are on their toes, a good specialist can help everyone if only by stimulation to do as well or better than he.

I do feel that the general men in this state have discharged their duty well, and those men who keep themselves refreshed through postgraduate courses and the other means available need not apologize for the medicine they practice, nor should they step aside with their years of successful experience for a young man who has just completed a residency.

It is my opinion that every man, be he in general practice or in a specialty (unless he is on a salary and even here it is true), must build his own practice, and if he will only bide his time and not starve to death in the process, he, too, will have a good practice in a few years.

After we complete our hospital training, it seems to take us all a few years to learn that we know a good many things that are not so.

Now to get back to the division of medicine. I do not think a general man is fair to the specialist who, for example, undertakes to treat a patient who comes to him with a foreign body in the eye, then through poor management bumbles along for five or six days, finally notices that the patient is get-

ting worse, and then in desperation calls for an ophthalmologist and expects him to say to the patient or his family, "The doctor has done everything he can under the circumstances."

I do not feel the specialist is to cover up the faults and wrongs of a doctor who has referred him a patient. On the other hand, when a patient has been referred honestly and sincerely as soon as the general man felt his colleague with more specialized training was needed, I do not think it fair for the specialist to make slighting and slurring remarks about care that has been sincerely and honestly given. As I mentioned a few minutes ago, the article in the Journal states that one should not make such remarks unless he is prepared to go into court and testify that a man has been criminal in his negligence. Where a physician has committed a fault in the care of a patient, a specialist can make a friend and help many more patients by tactfully calling his attention to what was wrong and how to handle such a situation.

It is also a fact that patients return from specialists to general men. Personalities, circumstances, hospital and office personnel and other factors have also played their part, and many times the general man is the one who must pour oil on troubled waters. Here, many times, long years of friendship between doctor and patient may be the potent force that affects a specialist's reputation.

No one can doubt the need of specialists in medicine, nor will specialists accept total care of patients, which makes general men needful, at least in small communities. One of the areas of difficulty is the field of charge.

I feel that within limits, charges by specialists should be no more than those of general men doing the same procedure. The first consideration is not the halo of gold about the specialist's head, but the band of mercy that is around his heart. It is the ability of the patient to pay that should be checked. A man with a large family and few resources is still a human being, and many specialists would be better off with a small fee in these cases, than not doing some of the work at all.

Of course, some specialized procedures should draw large and special fees. The general man may feel he is competing with the specialist and be very sure about his ability to do specialized procedures. But again, let us be realistic.

If we are competing with an allergist, for instance, are we giving the patient enough time to really get a history? Are we doing the proper tests? Are we getting nasal and other secretions and examining them through competent laboratory procedure?

If our competition is a Gyn man, are we in a position to offer total hysterectomies, vaginal hysterectomies, proper slides for Papanicolaou tests? Are we doing Rubin tests and uterosalpingography? Are we doing biopsies and actually examining our patients?

In other words, unless we are actually giving value received on a comparative basis, we are not being fair.

It is my observation that many men do not specialize, but many men limit themselves, thereby covering certain fields more completely, and I feel that herein lies some of the answers to some of our problems. Specifically, I feel that referring men too often send a patient to a specialist without history or physical findings, and definitely when we know of some idiosyncrasy or sensitivity of either the person or his personality, we will be doing both the patient and the doctor who sees him a distinct service by so doing.

It is evident by now that if one should explore this field to its ultimate conclusion, it would take hours. I am satisfied that Wyoming, at the present time, does not need a Ph.D. to do a urinalysis. I am equally sure our general men in this state will not be doing brain surgery.

All our problems of physician-patient relationship would be solved if we would all follow the teachings that Jesus laid down almost 2,000 years ago when he said: "Do ye unto others as ye would have them do unto you."

Skin Cancer and Sunlight *

O. S. PHILPOTT, M.D.,
A. R. WOODBURNE, M.D., and
J. A. PHILPOTT, JR., M.D.
Denver

A DISEASE often becomes associated with certain regions and may be named for the place where it originates. For that reason Coccidiomycosis is frequently called "The California Disease"; Rocky Mountain Spotted Fever is so called because of the site of its origin and Colorado Tick Fever is still another example. So far we do not recognize a "Mile High Disease," but it is true that all skin conditions stimulated by actinic sensitization are more commonly encountered here than in most parts of our country.

Sea faring people have long been familiar with "sailor's skin" and all over the great cattle country in this region are innumerable cases of a similar condition graphically described as "ranchman's skin." A leathery, well tanned hide seems as essential a part of a cowboy's equipment as chaps and spurs. Here, as elsewhere, acute sunburn is somewhat seasonal but, in addition, we also see many severe cases of acute erythema solare during the Christmas and spring vacations from neighboring ski resorts. In this location also troublesome chronic erythema solare is a year around problem.

Denver is not only the geographical hub of an extensive cattle raising empire but is likewise a medical center for an extensive area which by climate and environment is particularly suited to the production of premalignant and malignant skin changes. The high altitude, bright sun, clear air, wide open spaces—all these, coupled with a population largely engaged in outdoor occupations—means a high concentration of ultraviolet rays bombarding the exposed skin and these are factors which combine with time to produce weathering of the skin.

Weathering of the skin is not the result of a single vacation or an occasional picnic but results from long hours in the saddle or on the tractor, from herding sheep in the high ranges or irrigating the fields summer after summer. This weathering process is not solely the penalty of occupation but may be equally shared by the persistent golfer, the ardent outdoor sportsman and also those individuals of both sexes addicted to excessive sun bathing.

From this exposure inevitable cutaneous changes gradually occur. Superficial circulation is altered. Telangiectasia appears on the nose and over the cheek bones. The V of the neck becomes reddened and coarsened. One area may become atrophic while another area becomes greatly thickened but, in both processes, there is loss of skin elasticity. Pigmentary changes slowly take place, some places paling while others become progressively darker. The lips become scaly, fissured, thickened and even eroded. Dyskeratoses of different types and degrees develop. Some of these changes we purposely call premalignant, using this disputed term for its descriptive value to aid us in warning patients to take measures to prevent or at least delay these inexorable changes, the end result of which at times can be demonstrated to be skin cancer.

Evidence is accumulating that sunlight does cause skin cancer. Skin cancer has been experimentally produced by Findlay[1] exposing animals to ultraviolet rays in the range of 2500-3000 A.U. Investigation has shown skin cancer is more prevalent in the white races, and the lighter and thinner an individual's skin the greater his chance of developing skin cancer if exposed long enough.

Medical history shows a higher incidence of skin cancer among the English settlers who moved to Australia than among the Australians. In the Kenya Colony of Africa

*Presented before the Colorado State Medical Society in Denver, October 2, 1953, accomplanied by colored lantern slides of exemplary cases.

the elevation is somewhat comparable to that of Colorado and here too the English colonists develop a higher rate of skin cancer than the natives. Some explanation for the high incidence of skin cancer in Colorado may be that we have so many blue eyed, fair skinned descendants of those English and European settlers who homesteaded much of our territory in the seventies and eighties. Hall[2] points out that blue eyed individuals are especially susceptible to skin cancer.

The purpose of this paper is to point out that excessive sunlight may produce skin cancer. Patients should be warned against unnecessary exposure. Light complexioned individuals in outdoor occupations should be encouraged to adopt protective measures. They should be examined periodically. Suspicious skin changes should be watched and premalignant lesions promptly and effectively removed.

This is a rich field for those physicians interested in practicing preventive medicine. Statistics show that, while there is an increase in skin cancer, we may take satisfaction in knowing that there would be a great many more cases but for our diligence in seeking out and removing those suspicious skin changes constantly occurring during the long process of skin weathering.

REFERENCES

[1]Findlay, G. M.: Ultra Violet Light and Skin Cancer. Lancet 2:1070, 1928.

[2]Hall, A. Fletcher: Relationships of Sunlight, Complexion and Heredity to Skin Carcinogenesis. Arch. Derm. & Syph. 61:589, 1950.

Tumors of the Thyroid Gland*

JOHN W. CLINE, M.D.
San Francisco, Calif.

THERE is perhaps no more confused area in frequently encountered neoplasms than that involving tumors of the thyroid. Cancer of the thyroid is not a common disease but occurs sufficiently often that all must deal with it. It accounts for about 0.5 per cent of all cancer deaths but represents a larger proportion of clinical malignancy. The widely varying opinions of students of the subject appear to be based upon a number of factors. Most prominent among these are geographical distribution, divergent interpretation of microscopic pictures, the variability in the life histories of thyroid tumors and the hazy state of knowledge of basic thyroid physiology. Our knowledge of the thyroid gland has increased but has not reached the point that we can solve the comparatively simple problem of the hyperplasia of exophthalmic goiter except by the relatively crude means of interruption of the chain of events near its mid portion through the employment of surgery, radiation or anti-thyroid drugs. The Reinhoff concept that most multinodular goiter in adult women results from recurring cycles of alternating activity and involution now has general acceptance.

It is difficult to speak with assurance and impossible to be dogmatic concerning carcinoma of the thyroid. It is also difficult to reconcile the widely divergent views of competent observers. The variation in incidence of malignancy and opinions concerning it in different parts of the world and in areas of this country is greater than could be explained readily upon geographic and climatic conditions alone. Interpretation as to what constitutes carcinoma must play an important part. Despite the variations in statistical studies certain facts stand out. Cancer is rarely found in glands presenting diffuse hyperplasia, thyroiditis, simple goiter or enlargement in response to physiological demands. The previously so-called

*Presented before the 7th Annual Rocky Mountain Cancer Conference, July 8-9, 1953, in Denver.

"lateral aberrant thyroid" has been established to be the result of metastatic deposits of thyroid tissue from malignancy within the gland. The "metastasizing benign adenoma" is recognized as a misnomer.

Except in a possible rare instance, carcinoma arises from a single original nidus. The main controversy has centered about the relationship between pre-existing adenomata and carcinoma. Some observers believe all carcinomata arise from pre-existing adenomata. In certain large series the figures for previously known goiter run from 66 to 97 per cent according to the type of growth. This relationship cannot be ignored. A discussion of cancer of the thyroid, therefore, logically would begin with a consideration of nodular goiter. Single and multiple nodules occur in both sexes and at almost any age. One must try to analyze the significance of these conditions.

Single nodules in either sex and at any age show a high incidence of carcinoma. In some well studied series, this approaches 25 per cent. Nodular goiters in children have been reported to show carcinoma in as high as 40 per cent of cases. Multinodular goiter in adult females is eight to ten times as common as in adult males. The incidence of carcinoma in these cases is 3 to 5 per cent for females and may be as high as 16 per cent for males. Carcinoma arising in an otherwise normal gland will produce a nodule in time. It may, however, produce glandular or distant metastases before it becomes clinically demonstrable. Isolated nodules must always be considered malignant until proved to be benign. This is of great importance in children and males. Multinodular goiters in males and children are suspect until proved non-malignant. In women the incidence of cancer is much lower, but the likelihood of it cannot be ignored. This is particularly the case when some portion of the gland is enlarging or there is a history of recent growth. Abrupt enlargement of a pre-existing nodule, especially if associated with pain, may indicate hemorrhage into a cyst or adenoma, but does not exclude malignancy. Calcification, while more common in long standing endemic goiter, does not rule out carcinoma.

There is no pathognomonic sign of early carcinoma. The common textbook picture is that of advanced and usually hopeless disease. Large stony hard tumors, fixation, dyspnea, and usually even cough or recurrent nerve involvement are late signs, although the latter may result from pressure rather than invasion. When the clinical picture gives no real suggestion of carcinoma, gross evidence of it may be found at operation. The diagnosis also, may be made upon microscopic examination of the tissue removed even if not suspected because of the gross findings at the time of operation. These are important factors in ultimate prognosis. The five year survival rate with freedom from demonstrable recurrence in the cases in which a preoperative diagnosis of carcinoma has been made is 29 per cent. When the diagnosis is made at the time of operation, it is 43 per cent and when established solely by microscopic examination, it is 80 per cent.

The microscopic picture also influences end results. There are many and complex classifications of malignant tumors of the thyroid. For the purposes of practical consideration, three are sufficient—papillary carcinoma, malignant adenoma (Langhans, follicular or alveolar carcinoma) and all others. Fortunately, papillary carcinoma is the most common, representing 45 to 70 per cent in various series. It carries the best prognosis of the various types of cancer of the thyroid, and the more nearly it represents the pure papillary type the better the prognosis. Malignant adenoma represents about 10 per cent and the other types make up the residue. This category includes small cell, large cell, Hurthle cell and squamous cell carcinoma. Some of these are quite rare and most have bad prognoses. Competent and experienced pathologists often disagree as to the exact classification of a given tumor. Within each group the grade of malignancy varies widely and on occasion is subject to dispute. Various parts of the same tumor may present markedly different microscopic pictures.

In general, the papillary type tends to metastasize more slowly and primarily by lymph channels. Distant metastases usually

are late. Extensive local invasion seldom occurs early. It has a tendency toward a fairly high degree of cell differentiation. Repeated local recurrences may take place without demonstrable distant metastasis. It is more amenable to both surgical and radiation therapy, than other types of thyroid malignancy.

The course of untreated papillary carcinoma, while that of a malignant disease with an ultimately fatal outcome, may be so slow that the evaluation of therapy is difficult. Crile has reported one untreated case, diagnosed by biopsy, in which the patient remained in good health for twenty-seven years. The frequency of occurrence in young and otherwise healthy persons makes aggressive attack upon it possible. Lymph node metastases are usually ipsolateral. Contralateral metastasis occurs in about 13 per cent of cases, but we have not encountered it in the absence of involvement on the same side. Such cases are reported and Cope has drawn attention to the importance of the cricoid (Delphian) node which is situated in the midline above the isthmus. Our experience which coincides with that of others is that when cervical metastases exist the upper and posterior nodes may well be involved. The nodes in the thymic region also may show deposits of thyroid tissue. The nodes lying between the carotid sheaths laterally and the upper poles above and the pretracheal nodes in the immediate substernal area, however, are those most frequently affected.

Malignant adenoma tends to invade blood vessels early and hence distant metastasis may occur prior to lymph gland involvement and even before the local tumor is recognized. We have seen lung and bone involvement when the primary tumor was difficult to locate by clinical examination. Malignant adenoma also metastasizes to the regional lymph nodes. Lymph and blood vessel metastasis may be present simultaneously or one may precede the other. The primary tumor is slow to invade adjacent structures. This fact, plus the tendency to reproduce tissue which resembles normal thyroid, gave rise to the erroneous concept of benign metastasizing thyroid adenoma. The ultimately fatal course of this disease, if untreated, may be slow but usually is more rapid than that of papillary carcinoma. The prognosis is therefore less favorable but is superior to that of frank carcinoma.

The last group, as a rule, is locally invasive and metastasizes early by both blood and lymph channels. In most instances the prognosis is poor. Nevertheless, certain patients can be salvaged if they are properly treated. Not all are hopeless. X-ray therapy is usually quite disappointing but occasionally produces gratifying results.

Treatment

1. Preventive and early treatment. The ideal method is to prevent the development of cancer. Unfortunately, clinical, and even microscopic examination, does not tell us certainly which are precancerous lesions. Since about one out of four solitary nodules present carcinomatous change when removed, it is reasonable that many cancers may be prevented by removal of these nodules.

At times, what seems preoperatively to be an isolated nodule will prove at operation to be the most prominent of a number. We are compelled to rely upon clinical diagnosis in determining the indications for operation, and, therefore, such a mass must be considered to be a single adenoma prior to operation. It is our opinion that the following group of tumors should be explored surgically:

1. Solitary nodules in either sex and at any age.
2. Nodular goiters in children.
3. Nodular goiters in males.
4. Non-toxic nodular goiters in adult females manifesting any change except regression.
5. Nodular goiters with which pressure effects have become apparent (cough, voice change, dyspnea in certain positions or venous obstruction.)

Exploration is carried out through a transverse collar incision with or without an upper prolongation at the end correspond-

ing to the side of the tumor. The ribbon muscles are separated in the midline and may or may not be transected at a higher level. Adequate exposure is essential and one should not hesitate to extend the incision or divide the muscles to obtain it. The area of the nodule in question should be carefully examined for evidence of attachment to the muscles or other structures. If the muscle be involved it should be resected with good margin and not detached from the gland. The entire gland must be carefully explored for other tumors. Incision of the opposite lobe may be necessary if palpable induration or thickening be present. The area delineated by the superior poles above, the substernal region below and the carotid sheaths laterally should be investigated for enlargement or change in lymph nodes. If such are found they should be submitted to immediate frozen section. This method is reliable for demonstration of thyroid deposits in lymph glands.

There is considerable doubt concerning the reliance to be placed upon frozen section examination of portions of the thyroid itself. Some surgeons predicate further procedure upon the findings of immediate examination. Others find this method inadequate for such an important decision and believe that it may be misleading, in either direction. Our experience makes us reluctant to place much confidence in it. The interpretation of the microscopic findings in thyroid tissue may be difficult under the best of circumstances and multiple sections may be required.

Up to this point (with the exception of opinion concerning frozen section) there would be little disagreement about procedure. Beyond this point, there is considerable divergence of opinion.

2. Removal of the tumor. In the absence of local invasion or demonstrable metastasis the advocates of immediate frozen section predicate further procedure upon microscopic findings. The lesion is removed by local excision. If it be found to be benign, no further treatment is undertaken. Some remove the adenoma by enucleation and await permanent sections. If these show no evidence of malignancy, no further treatment is indicated. Still others approach the problem by doing a subtotal lobectomy instead of enucleation. A larger number subscribe to excision of the tumor by total lobectomy unless it is situated in the isthmus in which case wide wedge excision is performed. We prefer this method.

There are advantages and disadvantages to all methods. Frozen section, if positive and reliable, makes it possible to proceed with definitive treatment at once. The method may be reliable in certain hands, but we doubt that it is in most instances and the potentiality of leading to erroneously radical or erroneously conservative procedures must be recognized. Enucleation or, for that matter, subtotal lobectomy presents the danger of dissemination of tumor cells and neither can be considered adequate definitive therapy even for sharply localized malignant lesions. In addition, subsequent lobectomy must be undertaken in an unfavorable field.

We believe total lobectomy to be the procedure by choice. It presents greater hazard of recurrent nerve injury and removal of parathyroid bodies. The incidence of harm to these structures, however, is very low if care be exercised to protect them. Thyroid function seldom suffers by removal of one lobe. If the lesion appears to be confined to the gland lobectomy constitutes adequate definitive therapy except in an occasional instance. The procedure is more radical than necessary for benign lesions but we believe the advantages to outweigh the disadvantages and consider it the method of choice.

3. Multinodular goiter. If attention has been directed toward one portion of the gland, we believe that total lobectomy should be performed on that side. This is particularly true in males and children. A subtotal lobectomy should be done on the opposite side.

The general principles are the same as those applied in dealing with isolated nodules. If a subtotal thyroidectomy has been performed and unexpected carcinoma is found in the specimen, the remainder of the involved lobe should be removed as early as possible. In subtotal thyroidecto-

mies, it is wise to mark the lobes for identification. This will eliminate confusion as to the exact site of an unsuspected malignancy found only by section and microscopic examination.

4. Localized carcinoma with lymph node metastasis. There is widespread belief that the principles governing eradication of malignancy elsewhere should apply to cancer of the thyroid. Due to the peculiar behavior of certain thyroid neoplasms, some surgeons prefer to modify the procedure. The basic principles of the surgical treatment of cancer are complete local resection and adequate attack upon the areas of lymphatic drainage. The differences of opinion arise from varying concepts as to what constitutes satisfactory approach to both aspects of the problem.

As a result of the occasional presence of multiple carcinomatous foci within the gland, certain surgeons insist that adequate local resection requires total thyroidectomy. There can be no question that this is true if multiple foci can be demonstrated. Multiplicity of foci is quite rare and this attack seems unduly radical for a lesion which appears to be sharply localized to one lobe. In the vast majority of cases, lobectomy will suffice for the part of the treatment requiring complete local resection.

There are likewise varying opinions concerning the indications for resection of lymph glands in the drainage area. In the absence of demonstrable local extension and lymph gland involvement, some surgeons advocate "prophylactic" neck dissection. Most do not, and we believe this procedure to be unwarranted in most instances. Patients who have what appears to be sharply localized disease must be kept under observation and if metastases become apparent, must be treated accordingly. In the presence of demonstrable lymph node involvement, practically all surgeons recommend removal of the glands. The divergence of opinion comes in consideration of the nature and extent of the procedure. Our experience indicates that when the jugular nodes are involved invasion of the superior and posterior chains is sufficiently frequent that the procedure should aim to remove these glands on the ipsolateral side. The submental and submaxillary glands are seldom involved.

Some surgeons believe "picking out" the demonstrable glands to be adequate and others that dissection should be en bloc with removal of the sternocleidomastoid muscle and the jugular vein. We advocate the latter procedure because of frequency of extension beyond the primary zone of spread.

The jugular glands should be examined on the opposite side and if contralateral spread has taken place, the procedure on the second side must be less radical. Ligation and excision of both jugular veins at one time is hazardous. We have seen manifestations of increased incranial pressure including headache, choked discs and temporary confusion resulting from unilateral removal of the jugular vein for carcinoma of the thyroid with lymph gland metastasis. Under such circumstances, bilateral ligation could prove fatal.

5. Invasive carcinoma. If cancer of the thyroid be more extensive than that previously discussed, the prognosis is poor, but if it can be resected this should be done. The ribbon muscles, the entire thyroid gland, and the regional lymph glands should be removed. Occasionally, the results are unexpectedly good but a rapidly fatal course is usual.

6. Postoperative treatment. Papillary carcinoma is usually more sensitive to radiation than other types. Where lymph gland metastasis has taken place, we use it regardless of type but usually do not expect much benefit except in the papillary form. In cancer which has advanced beyond the hope of cure and that which is clearly inoperable, it provides the only chance of palliation.

Radioactive iodine has proved to be a disappointment to date. The uptake in normal thyroid tissue is almost always greater than in the primary lesion and the metastases. The greater the tendency to colloid formation in the tumor the greater is the uptake as shown by autoradiographic and counter studies. If other methods have been exhausted and a tracer dose shows reasonable uptake it can be used but with-

out much prospect of success. Some palliative effect and some actual tumor destruction have been demonstrated with large doses following total thyroidectomy and administration of thyroid stimulating drugs but as far as we know no important influence upon the course of the disease has been produced.

7. Technical considerations. In all radical attacks upon cancer of the thyroid, the recurrent laryngeal nerves and the parathyroid glands should be exposed and protected from injury. The removed specimen should be inspected for inadvertently removed parathyroid tissue, and if such be found it should be implanted in the muscles.

Conclusions

1. In control of cancer of the thyroid, almost complete reliance must be placed upon early and adequate surgical treatment.

2. Radiation is an adjunct to surgery in operable cases and usually an unsuccessful method of palliation in advanced cases.

3. The success of surgical treatment is primarily dependent upon the extent of disease.

4. No lump in the thyroid gland can be dismissed as of no consequence.

5. The maximum chance for cure is while the disease remains confined to the gland.

6. The first physician to see the patient has the best and perhaps the only chance to direct a successful course of treatment. It may be said that he has the opportunity to determine the ultimate prognosis.

*Programs to Reduce Neonatal Mortality**

R. L. CLEERE, M.D.
Denver

IN the United States during the past three decades, the mortality rate for infants under one year of age has decreased two-thirds. The reduced mortality, however, has been primarily among the older infants, the rate from deaths in the first month of life having dropped only 50 per cent while the rate from deaths between one month and one year of age declined 80 per cent.

National Office of Vital Statistics publications show that from 1920 to 1951 the total infant mortality rate dropped from eighty-six deaths to twenty-nine deaths under one year of age for each 1,000 live births. The neonatal mortality rate decreased from about forty-two deaths to twenty deaths under four weeks of age per 1,000 live births, and the rate for infants aged one month to twelve months declined from forty-four deaths to only nine deaths per 1,000 live births. With statistics such as these before us, the prime importance of saving lives in the neonatal period is clear, if the over-all infant rate is to be greatly diminished in the future.

The infant and neonatal mortality rates vary, of course, from state to state and from locality to locality within the states. In this paper, figures for Colorado from 1940 through 1951 will be used for a statistical analysis of the broad aspects of the neonatal mortality problem, followed by a discussion of public health department studies and programs directed toward further lessening of the death toll among young infants.

Statistical Picture

Both in Colorado and the United States, the neonatal mortality rate has been re-

*This paper is based upon a lecture delivered, with slides, at the Postgraduate Course for Physicians on Medical and Surgical Problems of Newborn and Premature Infants, University of Colorado School of Medicine and the Colorado State Department of Public Health, March 25-27, 1953, at the University of Colorado Medical Center

†Executive Director, Colorado State Department of Public Health, Denver.

Special acknowledgements are due John A. Lichty, M.D., Pediatrics Consultant of the Colorado State Department of Public Health, and Associate Professor, Department of Pediatrics, University of Colorado School of Medicine, for materials and suggestions used in the preparation of this paper. Charles H. Dowding, Jr., M.D., Chief, Maternal and Child Health Section, Colorado State Department of Public Health, also provided materials, as did other department staff members.

new

9-city study

confirms value

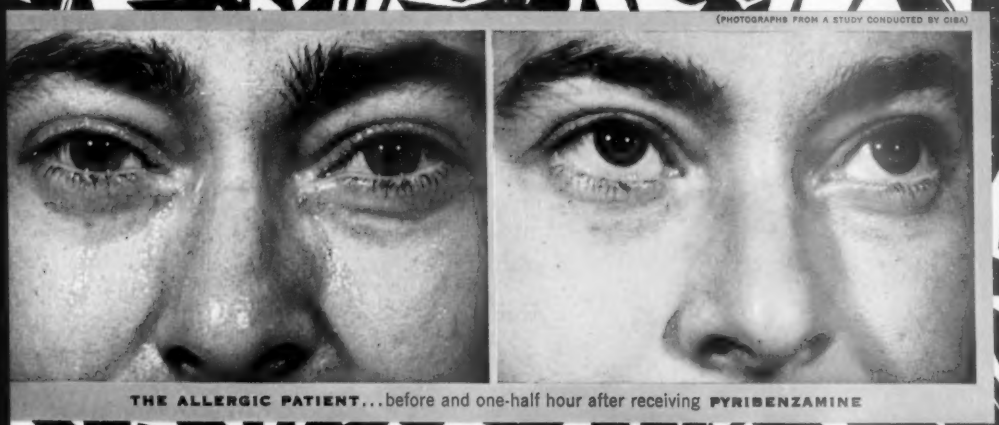
of

Pyribenzamine®

in ragweed hay fever

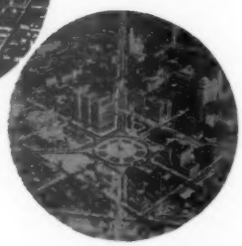
In the summer and fall of 1953, nine prominent allergists, representing every section of the country except the West Coast, tested Pyribenzamine in a total of 832 patients with ragweed hay fever. The work of these men is significant because of its scope and because it is the most recent major study of antihistamines.

Certain observations are particularly worth noting . . . →



(PHOTOGRAPHS FROM A STUDY CONDUCTED BY CIBA)

THE ALLERGIC PATIENT...before and one-half hour after receiving PYRIBENZAMINE



...of the 832 patients who were given Pyribenzamine, only 84 did not obtain some degree of symptomatic relief.

From this study and from previous investigations involving thousands of allergic patients, one fact is clear: Pyribenzamine gives the allergic patient unsurpassed benefit with antihistamine therapy.

Pyribenzamine® hydrochloride
(tripelennamine hydrochloride CIBA)

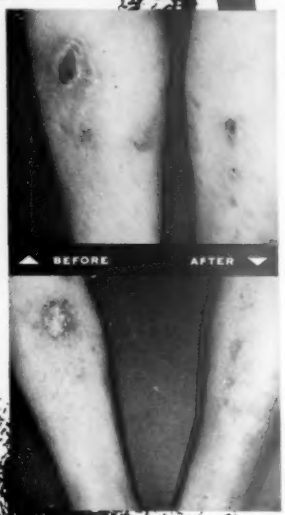
Try Pyribenzamine – the most prescribed antihistamine – in hay fever, in every allergy susceptible to antihistamine therapy.

Pyribenzamine 25-mg. tablets (coated) and 50-mg. tablets (scored) both available in bottles of 100 and 1000.

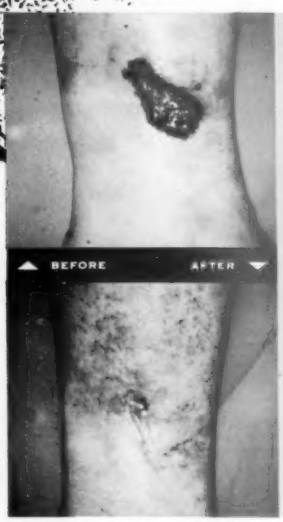
CIBA

more blood to the periphery with

Priscoline®



BILATERAL ARTERIOSCLEROTIC ULCERATION in patient age 65. At start of Priscoline therapy; ulcer, right leg, 1¾" x 1¼"; ulcer, left leg, ½" x ½". With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



HYPERTENSIVE ISCHEMIC ULCER of right leg in patient age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

Increases blood flow to the extremities through a direct vasodilating effect on vessel wall, a sympathetic blocking effect, and an adrenolytic effect—

A valuable aid in the treatment of peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, and other trophic manifestations—

Priscoline hydrochloride available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Priscoline® hydrochloride (tolazoline hydrochloride CIBA)

PHOTOGRAPHS AND CLINICAL DATA BY COURTESY OF R. I. LOWENBERG, M.D., CONSULTANT IN VASCULAR SURGERY, CONNECTICUT STATE HOSPITAL, MIDDLETOWN, CONNECTICUT.

CIBA

3/7470

duced one-third since 1940 as shown by the following comparative figures, from National Office of Vital Statistics sources, except the Colorado rates for 1950 and 1951, which are based upon the State Health Department's tabulations.

Neonatal Deaths per 1,000 Live Births in:	Colorado Residents	United States
1940	33.4	28.8
1945	28.3	24.3
1950	23.4*	20.1*
1951	24.2*	20.2*

*Preliminary figures.

County Variations: Although the neonatal mortality rate for Colorado remains somewhat higher than that for the United States, the comparison is more favorable for many of the individual counties. The bright portions of the Colorado picture, however, are partly counterbalanced by darker areas where excessively high county rates indicate need for studies into the underlying local problems.

In order to minimize any biases due to chance circumstances of a single year's experience, neonatal mortality rates were computed according to county of residence for the three-year period 1949-1951, from the State Health Department tabulations. Excluding the extremely high but probably unreliable rates for four counties with small populations and few births, the median three-year rate for the fifty-nine other counties of the state was twenty-three deaths under one month of age per 1,000 live births. Ten counties had rates at least 25 per cent below the state median, and half of these were 50 per cent or more below the median. On the other hand, fourteen counties had rates 25 per cent or more above the state median, and nine of these rates were at least one and one-half times the median. For one mountain county, which will be discussed later in relation to a special study made there, the rate was slightly more than twice the median for the state.

Attendance at Birth: The type of attendance provided at birth is a possible factor in infant mortality regarding which statistics are compiled routinely from the birth certificates. Ninety-five per cent of the live births to Colorado residents in 1951 were attended by physicians in hospitals or maternity homes; 4 per cent were attended by physicians elsewhere; and 1 per cent were not attended by physicians. The percentages diverged very greatly, however, for some of the counties. The live births unattended by physicians ranged as high as 20 per cent, in two counties; and those attended by physicians but not in medical institutions ranged up to 44 per cent, in one county.

Age and Birth Weight: Tabulations of infant deaths according to age show, consistently, that by far the major portion occur within a month of birth and also that the first day and the first week are the crucial periods for survival. In the three years 1949-1951, 70 per cent of the deaths of Colorado infants under one year old occurred in the first month. For deaths under one month old, the age distribution was this:

Total 2,449 neonatal deaths	100%
Under 1 hour	12
1 hour to 1 day	48
1 day to 1 week	27
1 week to 1 month	13

Outstanding also in the statistical data on infants not surviving the first month are the facts on immaturity, or prematurity, from the standpoint of small birth weights. By matching infant death certificates with birth certificates, the Records and Statistics Section of the Colorado State Health Department was able to find the birth weights for 1,562, or 95 per cent, of the 1,649 resident neonatal deaths in the two-year period 1950-1951. In 72 per cent of the neonatal death cases with known birth weights, the infants weighed not more than 5½ pounds at birth and, therefore, were immature according to the definition now in use for statistical classification purposes. Here is the detailed weight distribution of the neonatal deaths studied:

Total 1,562 neonatal deaths with known birth weights	100%
5½ lbs. and under	72
Under 2 lbs.	17
2 to 3 lbs.	18
3 to 4 lbs.	15

4 to 5 lbs.	14
5 through 5½ lbs.	8
Over 5½ lbs.	28

Prematurity, unquestionably, is a major field for continuing attack.

Health Department Programs and Special Studies

Activities for reduction of neonatal mortality are integral parts of the general maternal and infant health program of the State Health Department of Colorado. The services and projects most directly related to the survival and health of young infants may be briefly described under seven headings, as follows:

Maternal and Infant Health Supervision: The state and local health departments emphasize early prenatal care by the family physicians and proffer public health nursing and clinic guidance for prenatal, postnatal, and infant cases. Services of the State Health Department's consultant team on maternal and infant health are available to all physicians, clinics, and hospitals. Home visits are made by local public health nurses to ante-partal and postpartal patients and to infants, on referral by private physicians and clinics. In many communities, group teaching is provided by public health nurses through classes for expectant mothers.

The maternal and infant health consultant team of the State Health Department includes the Chief of the Maternal and Child Health Section and the Obstetrics, Pediatrics, Medical Social Work, and Maternity and Infancy Nursing Consultants. They, in turn, work closely with the University of Colorado Medical School and Center and with the state and county medical societies. The Obstetrics Consultant and the Pediatrics Consultant are jointly employed by the State Health Department and the Medical Center.

Cooperation in Premature Infant Center Projects: The State Health Department administers the funds for the Premature Infant Center projects at the University of Colorado Medical Center. This program was started in 1947 with financial aid from the United States Children's Bureau and continues to receive generous grants from the Bureau.

The Maternal and Child Health Section of the Department develops the public health aspects of the Premature Infant Center projects and services, and the Obstetrics Consultant and the Pediatrics Consultant coordinate the public health, medical, research, education, and training aspects. In 1950 a Maternity Care Project was initiated at the Premature Infant Center to conduct services, research, and training related to prevention of premature deliveries and improved care for mothers with complications of pregnancy.

Provision of Incubators: Forty-five state-owned incubators for prematures have been made available to the physicians and hospitals of Colorado by the State Health Department. Ten hand-portable incubators are kept at local health departments, primarily for transporting prematures to general and surgical hospitals. Thirty-five hospital-type incubators are kept in two pools—one at the Premature Infant Center, University of Colorado Medical Center, for distribution to hospitals throughout the state upon call; and the other at Denver General Hospital, for distribution to other hospitals in the city as needed.

Newborn Facilities Standards and Consultation Services: The standards set by the State Health Department of Colorado for hospital licensing and guidance purposes specify newborn nursery facilities and procedures that are similar to the American Academy of Pediatrics standards. Small hospitals are encouraged to provide care for noncomplicated prematures. During 1951 a committee of nurses and State Health Department representatives prepared a manual on obstetrical and newborn nursing care. This publication is distributed to all hospitals and public health nurses in the state.

Improved and expanded facilities for the newborn have resulted from advisory services on hospital buildings and equipment, and from federal aid for hospital construction under the Hill-Burton Act. Under a grant from the W. K. Kellogg Foundation, consultant services by an expert on hospital administration and diagnostic services have been available through the State Health Department for the past year. Considerable progress has been made in planning more

effective use of the hospital facilities and in studying possibilities of sharing the services of specialists such as pathologists, especially in rural areas. In some parts of the state, hospital councils have been formed to carry forward such joint planning and cooperative services.

Community Research and Planning Projects: The State Health Department's team of maternal and infant health consultants often arrange with the local medical society, health department, and other interested groups to study the special needs of a community or area. For example, under plans developed by the consultant team, county medical society, and local hospital, a study of all aspects of maternal and infant health and mortality was made in 1952 in the mountain county previously mentioned. The project stemmed from vital statistics analyses begun in 1949 that indicated the unusually high incidence of prematurity in the county. Following considerable joint consultation and local action during the next two years, a physician working with the State Health Department and Medical School conducted mother interviews and related inquiries over a period of several months in 1952. In addition, a specialist from the State Agricultural College collected dietary histories of the mothers. The data now are being analyzed.

In the meanwhile certain hospital practices related to obstetrical and newborn care have been improved in conformity with recommendations made by consultants. Future mortality trends will be followed with great interest in the hope that continuing progress will result from the community projects.

Postgraduate Education: Numerous postgraduate and refresher courses for physicians and ancillary personnel are offered by the Colorado State Health Department and Medical School. Graduate courses of three or four days have proved valuable to physicians and health officers. Subject materials from obstetrics, pediatrics, nursing, medical social service, and public health are presented in the physicians' courses on maternal and infant health. For graduate nurses, a course on principles of nursing and medical management of premature infants is given quarterly at the Premature Infant Center; and for medical social workers, three-day institutes concerning premature infants are conducted periodically.

Statistical and Medical Use of Vital Records: In Colorado, the State Health Department makes detailed annual tabulations, statistical analyses, and trend studies from the birth certificates and the infant and maternal death certificates. Infant death certificates now are matched with the birth certificates routinely. In addition, a consolidated punch card has been designed for machine tabulating the combined information from the matched certificates in order that natal and postnatal factors in the infant deaths may be jointly analyzed. With the approval and cooperation of the Committee on Maternal and Child Health of the State Medical Society, the State Health Department presents an analyzed infant death case in the Rocky Mountain Medical Journal about every two months.

Recently the Maternal and Child Health Committee of the State Medical Society and the Obstetrics Consultant and Pediatrics Consultant of the State Health Department have been formulating a statewide plan, already in operation in several Denver hospitals, for continuous medical analysis of fetal, neonatal, and maternal deaths through regular conferences between local medical society committees and hospital staffs. Such conferences are proving helpful in reviewing events prior to the fatalities and in considering means of further improving the related medical and hospital procedures.

Likewise to facilitate research in this field, the State Health Department has under consideration a fetal death certificate to replace the stillbirth certificate now in use. Good progress has been made in drafting the proposed fetal death form. The World Health Organization definitions of a live birth and of a fetal death are being used in this connection. The definitions are:

> Live birth is the complete expulsion or extracting from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not

the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born.

Fetal death (exact opposite of live birth) is death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

When studies of vital records are combined with postmortem examinations and other pathological and medical research, additional information of practical value to the practicing physicians results. In the following listing, the anatomic causes of 8,905 neonatal deaths established by satisfactory postmortem examinations in studies conducted in Chicago, 1936-1949, are shown as percentages of the total. Although the classification does not show immaturity, or prematurity, as such, this condition was involved in many of the deaths.

Total 8,905 neonatal deaths with satisfactory postmortem examinations	100.0%
Abnormal pulmonary ventilation	43.7
Injuries at birth	16.6
Malformation	15.8
Infections	13.4
Blood dyscrasias	5.3
Anoxia	3.8
Miscellaneous	1.4

The preceding statistics are from a detailed report by Dr. Herman N. Bundesen and associates in the Annual Report of the Chicago Health Department, 1951. Physicians in Colorado and other Rocky Mountain states also can contribute greatly to knowledge on the causes of neonatal and fetal deaths by having postmortem examinations made in as many instances of these fatalities as possible.

Teamwork for Further Progress

The practicing physicians are the vanguard in the continuous campaign against avoidable infant losses. Minimal occurrence of prematurity and neonatal mortality and maximal maternal and infant health will be achieved through the teamwork now integrating the physicians' care and the services of hospital staffs, pathologists, public health nurses, vital statisticians, and other state and local health department personnel.

Surgical Management of Cholecystic Disease*

ROBERT WOODRUFF, M.D., and ALBERT E. JAMES, M.D.
Denver

CHOLECYSTITIS and its complications, both attributable to the disease itself, and to injudicious medical and surgical management, continue to be an important part of the work of those engaged in the practice of general surgery. Therefore, it seems to us that from time to time a careful analysis and evaluation of the methods of management of these cases is worthwhile so that we may continue to strive to reduce the morbidity and mortality resulting from this relatively common surgical condition.

This presentation is based on a series of 114 consecutive cases of primary cholecystic disease operated on by the authors between January 1, 1947, and December 31, 1952. It is felt that this series is a good cross section of what the average general surgeon in private practice sees in his everyday practice. During this period two cases of primary malignancy of the biliary system were encountered. It is recognized that the series is too limited in size to be of particular statistical significance, but because all phases of the management of these cases were di-

*Presented at the Colorado State Medical Society Meeting, Denver, September 30, 1953.

rectly under the authors' care, they were particularly able to evaluate the merits of various methods of management as applied to these cases.

Diagnosis in this disease assumes the utmost importance. It is generally agreed that many poor results of cholecystectomy can usually be explained by the fact that diagnosis of surgical cholecystitis was not well substantiated. In almost all instances of clinical cholecystitis, surgical intervention will reveal the gallbladder to contain stones; 101 or 88 per cent of the cases in our series were found to contain stones. This is in agreement with authors in the literature, who present an incidence of from 85 to 90 per cent in well selected series. Therefore, in the absence of calculi or definite histological evidence of inflammation, it is questionable that the surgical procedure was well indicated. It is those cases without evidence of real inflammation or without stones, that make up the group from which we get the poor results of cholecystectomy. These are the patients who complain they are worse since their operation. That they are worse is explainable. In addition to their functional condition, they now have an incision scar to worry about. When stones are present and operation complete, results of surgical treatment are usually excellent. We occasionally encounter a case in which no stones are found and diagnosis of cholecystitis is dubious and results of surgical treatment excellent. Whether these were cases in which the calculus material had passed from the organ or whether it represents a precalculus stage of the disease, we cannot always say, but these are usually cases in which clinical diagnosis was well substantiated. From the above discussion, it is our opinion that the most important factor to assure satisfactory results in surgical treatment of cholecystitis is proper diagnosis and selection of cases for surgery. Diagnosis of surgical cholecystitis is based on history, physical findings, and confirmatory evidence of cholecystography. Of these, history is most important. Physical examination usually adds little except in acute disease. However, when it is present, localized tenderness over the gallbladder is helpful.

History of classical gallbladder colic is pathognomic of the disease. The colic is usually brought on by partial or complete obstruction of the cystic or common duct, classically from stones. The stimulating effect on the gallbladder by over-ingestion of fatty food, often initiates the train of symptoms. The patient characteristically first complains of excessive gas and epigastric fullness which soon changes to actual pain. Pain or colic becomes more intense and characteristically shifts to the right upper quadrant with radiation to the back and corresponding shoulder. Relief is often, and then only partly, relieved by the "hypo". Vomiting is a variable accompaniment and the vomitus usually contains bile. This symptom complex varies considerably in intensity and the various factors assume greater or less importance. However, the underlying pattern of events is usually present. The patient may give a story of intolerance to fatty foods but that symptom is difficult to evaluate in absence of other confirmatory evidence. Table 1 lists the incidence of important symptoms and findings in this series of cases.

TABLE 1
Important Symptoms and Findings

Years Gall Bladder History **Average 4.8 years**
Longest 32 Years
Shortest 2 Months

Gallbladder Colic	64 or 56%	
Gallbladder Dyspepsia	92 or 80%	
Jaundice	18 or 15%	
Cholecystogram	85 or 74%	
Lithiasis by X-ray	62 or	54% Total 73% X-rayed

Gallbladder Function (by x-ray):
29 Non-functioning or 34% x-rayed.
36 Poor function or 42% x-rayed.
20 Good function with stones, 24% x-rayed.

Comment on cholecystography is in order. Patients in whom obvious stones are present, whether there is function or non-function of the gallbladder, pose no problem. Those patients in whom a good history of gallbladder disease exists and in whom confirmation by a non-functioning gallbladder is made, also pose no real problem. It is the

patient with an equivocal history in whom a poorly functioning gallbladder is reported that is most difficult to evaluate. It is in this patient that the gallbladder will appear normal at surgery and its removal will usually serve to accentuate his functional complaints. Again, the patient with a good history in whom x-ray is reported as normal deserves special attention. Repeated examination by the radiologist will often reveal small calculi which will layer out in the dependent position. Of course other pathology of the gastrointestinal tract must be ruled out, especially in those where findings are debatable.

In the face of diagnosis of cholecystitis with probability of stones, surgical intervention offers the only practical solution of the problem. Medical management is only a temporary, and then dubious, benefit. Procrastination in proper management of cholecystitis invites further and more severe symptoms with the danger of superimposed inflammation, empyema, gangrene, perforation, peritonitis and then the possibility of stone passing into the common duct is always present. This may lead to jaundice and liver damage and surgery will have to be performed under more hazardous circumstances. We must also consider that long standing cholelithiasis may be the initiating factor in gallbladder malignancy.

The chronic case is ordinarily operated on as an elective procedure. The difficult problem is to decide when to operate the case with acutely active disease. There are many proponents of immediate or early operative intervention in the case of acute cholecystitis. In this we are in accord. However, the main problem is to decide which case is acute cholecystitis. Many presentations on this problem in the literature are not too clear on that point. Some include simple acute gallbladder colic which is not necessarily an inflammatory process. In management of our cases, we include only those as acute cholecystitis which show definite evidence of an acute inflammatory process superimposed on gallbladder colic. This is shown by marked and increasing tenderness, rebound tenderness, muscle spasm and other signs of peritonitis together with chills, fever, increased white blood count and other evidence of generalized infection. One must be wary of interpreting pathologic findings in the light of clinical findings. Intensity of clinical findings does not necessarily reflect the degree of the pathologic process. With minimal findings one may encounter an extensively inflamed gallbladder with gangrenous changes. The converse is often true. Maximal clinical findings may reveal only minimal acute pathological changes. Because of the generally impaired blood supply in the aged, ischemia, gangrene and perforation occur relatively early following onset of the obstructive process. It behooves us to be especially alert in managing this disease in the older age groups.

Our plan of management of the acute gallbladder process is as follows: On admission to the hospital, the patient is evaluated as to general physical condition and stage of his gallbladder disease. Immediate measures are taken to restore the general physical condition to optimum by replacing fluids and electrolytes to normal levels with use of such measures as are indicated. If it is decided that the process is uncomplicated gallbladder colic, a conservative regimen of supportive measures is initiated with frequent re-evaluation for signs of a progressive acute inflammatory process. Should they appear, the case is then managed as an acute cholecystitis from that point on. If and when the process is judged an acute inflammatory process, appropriate antibiotic or chemotherapy is started in addition to other replacement therapy. If the patient's general condition is satisfactory and fluids and electrolytes have not been appreciably disturbed by vomiting and progressive dehydration and the inflammatory process is definite and obviously progressing, plans are made to carry out surgery. Should the diagnosis of inflammation be equivocal or should fluids and electrolytes need replacement because of appreciable loss, a conservative regimen of supportive measures and replacement is started. The patient is re-evaluated in four to six hours. If the inflammatory process is subsiding, a conservative program is maintained. If it is

stationary or progressing, we proceed with surgical intervention. We do not feel that a long history of the acute attack is a contraindication to surgical intervention. If the process has been of long duration, the chances of subsiding spontaneously are much less and it is more imperative that surgery be embarked on before more serious complications develop. In our group of cases fourteen, or 12 per cent, were judged acute cholecystitis on admission or progressed to that point under observation; twelve of these cases were treated by emergency surgical intervention. In this group there was one postoperative death. This occurred thirty days following surgery in an eighty-two year old man. This was the single mortality in the entire series. Autopsy in this case revealed acute pancreatitis, pericarditis, and pneumonia. Cholecystectomy was carried out at the primary operation in ten of these cases. In the two other cases, because of findings at surgery, cholecystostomy with drainage of the gallbladder and removal of stones was carried out. Both of these cases required subsequent cholecystectomy. In most cases of acute cholecystitis, we have found removal of the organ to be relatively easy because of the edematous condition of pericholic tissues with easy separation of structures along cleavage planes. We believe the following points give support to removal of the acutely inflamed gallbladder as soon as diagnosis is established and patient's condition is satisfactory. First, as previously mentioned, the only treatment of the disease is removal of the organ and the sooner that is accomplished, the less danger of more serious complications and the patient will be back to normal health and the less will be his economic outlay. It is felt by us and substantiated by others, that actual operation does not carry any more risk and that any actual mortality increase can be ascribed to severity of the disease rather than surgery. Of course, delay in surgical treatment may allow further progression of the disease with serious complications of gangrene, perforation, bile peritonitis, liver abscess and the necessarily high mortality accompanying these conditions.

After experimenting with various incisions for this disease, we have developed a great preference for subcostal approach, carrying medial end of incision as high as possible and carrying it slightly across midline. Muscles are cut in line of incision. Gallbladder is exposed and mobilized away from surrounding structures. The common bile duct is identified and decision made whether to explore it or not. The absolute indications for that are presence of jaundice or definite history of jaundice, dilated duct or duct with thickened wall, stones palpated within the duct, or presence of small stones in the bladder with a patent cystic duct through whose lumen a stone could pass. Other less definite indications are the presence of pancreatitis that might benefit from common duct drainage and absence of stones in an obviously inflamed gallbladder with possibility they had passed from the organ and might be lodged within the common bile duct. Using these indications, we have explored thirty-seven common ducts as part of the primary procedure in this series. In twelve of those ducts explored calculi or calculus debris was encountered. This gave an incidence of common duct exploration in 32.5 per cent of cases with 32.5 per cent of those explored containing stones and 10.5 per cent of the series containing stones in common duct. Another point that deserves comment is management of the cystic duct. The hazards of damaging the common duct by carelessly amputating too close to that structure are well known. However, it is equally important that not too large a stump of cystic duct be left, inasmuch as it may be responsible for a continuation of symptoms. A case in point is a 58-year-old female with history of repeated episodes of upper abdominal pain with nausea and vomiting. History revealed she had a cholecystectomy performed twenty years previously. Although the organ contained stones, the patient continued to have trouble as described. Exploration of her common bile duct was carried out. Probes were easily passed up both hepatic ducts and into the duodenum without encountering obstruction. Further exploration revealed a nubbin of cystic duct embedded in heavy scar tissue. Removal of

this was carried out. Fig. 1 shows a photograph of the specimen with the stone. We are strong adherents of drainage of the gallbladder bed to the outside in all cases where gallbladder is removed. This is necessary because one cannot predict which cases will drain bile because of severance of bile radicals between bladder and liver. Our policy is to carry out T tube drainage of all common ducts explored. On four occasions in this series, common ducts were closed without the customary drainage as advocated by other authors. Two of these cases drained considerable bile which most likely leaked through the duct closure. After re-evaluation, we believe that the routine drainage of the ducts has much in its favor and little against it.

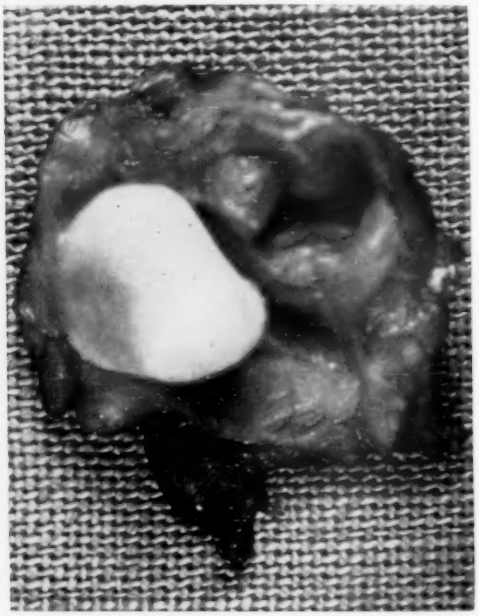


Fig. 1. Residual gallbladder stump with contained stone.

As stated, there was one postoperative death in this series. Table 2 lists the incidence of postoperative complications encountered. The complication of late fever rise which occurred from seventh to twelfth day in five cases deserves special comment. In two, it was apparently due to purulent material in the drainage tract, but in three cases it was probably due to bile accumulation in spite of the drainage carried out. There were no wound disruptions in this series and as far as is known, only one case developed a subsequent incisional hernia. This was a patient who developed postoperative pneumonia which was accompanied by severe coughing and abdominal distension.

The fair, fat, fertile, and forty females did not predominate in our series. There were seventy-six females to thirty-eight males, a ratio of 2:1 females over males. Age incidence showed wide discrepancy from the youngest of four years to oldest of eighty-two years, an average age of 47.5 years. Of special interest was the youngest, a four-year-old female child who had a cholecystectomy for acute hemorrhagic cholecystitis which contained concretions, but no actual stones. She had been hospitalized only a month before for acute hemolytic anemia of unknown cause. Increase in red cell breakdown products through the liver, with probable precipitation, undoubtedly played an important role in etiology in this particular case.

TABLE 2

Postoperative Complications

Wound Complications:

Infection:

4 wound infections
2 drainage tract abscesses
2 protracted bile from drain wound
1 T tube fistula

Pain:

3 painful wounds
1 reopened with little help

Hernia:

1 known

Pulmonary:

2 pneumonitis or atelectasis

Stones or Colic:

2 colic—possible CD stones
1 calculus on cholangiogram

Latent Fevers: (7-12 PO day) Total 5

2 due to drain tract infection
3 bile backup in spite of drain

Deaths:

1 acute gallbladder (82 yr. old male—pneumonia, pericarditis, pancreatitis).

The majority of these cases were followed by us for six months or more. A subjective questionnaire was sent to each patient in this series. Follow-up through questionnaire

was obtained in seventy-five cases and serves as a basis for a summary as shown in Table 3. In no instance was secondary surgery carried out on the biliary tract of any of these patients. However, there are two cases in whom the pain described in the questionnaire suggests further biliary tract disease. Re-exploration of these might find retained stones in the biliary passages. However, none of these have had evidence of jaundice or have had symptoms severe enough to warrant further surgery. Of the patients not satisfied with results of operation, three were from the group not having cholelithiasis.

TABLE 3

Relief of Symptoms	Yes	No		
Total	72	3		
Pain (suggesting colic)	5	70		
Jaundice	2	73		
Other Biliary Surgery		75		
Incision Pain	5	70		
Results Satisfactory	70	5		
	No residual	Better	Worse	Same
Indigestion:	51	17	2	5

In summarizing this presentation, we wish particularly to stress the excellent results obtained in well selected cases. In this series there were only five cases that considered they had poor results and three of these did not contain stones and on further evaluation probably did not present a good clinical story for gallbladder disease. The other poor results might possibly warrant further exploration.

Sandpaper Abrasion Treatment of Facial Scars

ERNEST A. STRAKOSCH, M.D.
Denver

GRATIFYING results obtained by sandpaper abrasion of tattoos and freckles has previously been reported[1]. The purpose of this report is to acquaint the profession with the use of this method for treatment of facial scars, particularly postacne scars. We, as dermatologists, treat acne primarily to prevent the sequela of disfiguring facial scars and personality changes sometimes associated with them. Yet when pitting follows, we often failed to help the patient.

Groundwork in the abrasion technic was done by plastic surgeons[2,3] who long before us experimented with it and finally obtained encouraging results. They deserve credit for pioneering in this field. The technic, be it sandpaper or the recently described procedure of Kurtin[4], is not too difficult to acquire and results are gratifying in most cases. As a matter of fact it has been among the most gratifying work I have done in our so-often frustrating specialty.

Report of Cases

The sandpaper abrasion technic has been used by me in 51 cases of facial postacne scars, 4 cases of severe smallpox scars, 9 cases of extensive freckles on face and body, and 3 cases with disfiguring facial scars from car accidents.

All were performed in the hospital, patients admitted on the day of operation and discharged the following day. Intravenous sodium pentothal was used as an anesthetic in 95 per cent of the cases. Only in the deeply scarred male patients was it supplemented by gas or ether through an intratracheal tube. The skin area was thoroughly washed with aqueous zephiran solution. The area involved was abraded with sandpaper[5], grit No. 1/0 and 2/0. The sandpaper used has been rolled around gauze rolls about

2 in. in diameter and 5 in. long, kept in place by rubber bands, and autoclaved. The area is abraded using considerable pressure until bleeding is profuse. The blood is washed off with a gauze sponge soaked in warm saline solution containing epinephrine (30 c.c. of 1:1000 epinephrine hydrochloride to 1,000 c.c. saline solution). This is important to keep the field clean and to remove all grit particles which may lead to foreign body reactions. The skin is abraded until it shows a granular appearance at which point it is temporarily covered with saline gauze (see above). Then the next area is abraded, and so on. At completion of the procedure the saline-gauze is removed, capillary bleeding having stopped. The abraded area is closely inspected to detect any pits that may have been missed. It is often necessary to re-abrade the whole area, or parts of it, a second time. It is also necessary to make sure that all the bleeding has stopped before the final bandage is applied. The areas are then covered with Terramycin gauze and a pressure bandage, using

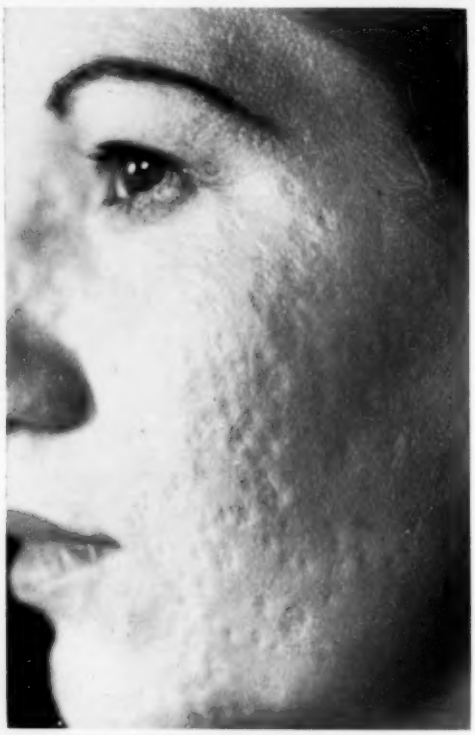


Fig. 1. Smallpox scars before operation.

Fig. 2. Four weeks after operation.

elastoplast. This bandage is kept in place for two weeks. At the end of this time, if gauze is still adherent, it may be removed by soaking with warm water for a few minutes, thus facilitating its peeling off without tearing new epithelium. The skin at this time is of pink color, and may be cleansed thereafter with soap and water. Male patients are allowed to shave, using an electric razor. The pink color fades within two to three months. Female patients are permitted to use a foundation lotion make-up after a few days.

Comment

In about 5 per cent of patients the formation of milia were observed, usually appearing about one month after operation. Monash and Rivera[6] recently reported 25 per cent occurrence of milia in cases treated with a revolving metal brush. The sequela is inconsequental, the milia being removed in the usual manner. It is imperative to have the

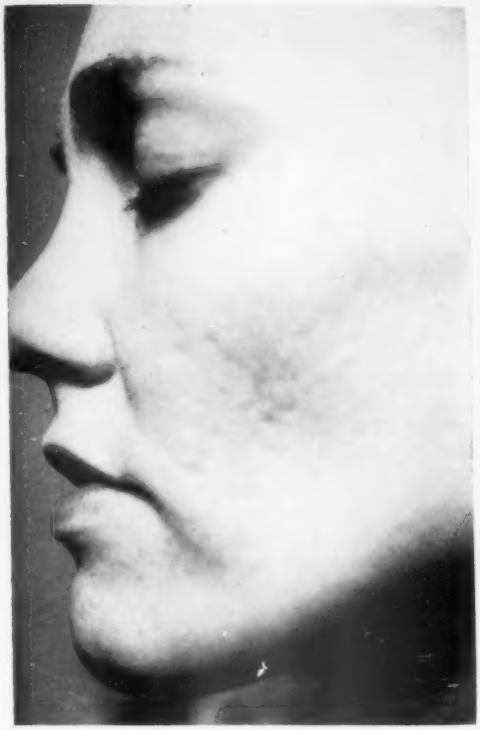


Fig. 3. Acne scars of various depth before operation.

active acne process well under control before the scars are removed.

The cosmetic results obtained were excellent when the pits were rather shallow (Figs. 1 and 2). When the pits were of various depths, improvement ranged in my opinion, from 60 to 80 per cent. In these cases one is able to remove the shallow pits, while the previously deep ones become shallower (Figs. 3, 4). In four instances remnant pits were re-abraded about six months after the first operation with additional benefit. It is important to have good

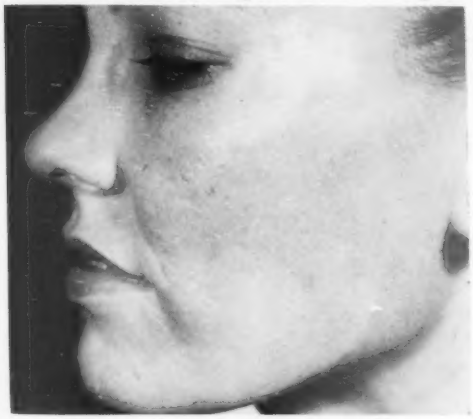


Fig. 4. Four weeks after operation.

black and white photographs of the areas before operation. Results may then be judged objectively.

REFERENCES

[1]Strakosch, Ernest A.: Sandpaper-Abrasion Treatment of Tattoos. A.M.A. Arch. Dermat. & Syph. 67:53, 1953.

[2]Iverson, P. C.: Surgical Removal of Traumatic Tattoos of the Face. Plast. & Reconstruct. Surg. 2:427, 1947.

[3]McEvitt, V. G.: Treatment of Acne Pits by Abrasion Sandpaper. J.A.M.A. 142:647, 1950.

[4]Kurtin, Abner: Corrective Surgical Planing of Skin. A.M.A. Arch. Dermat. & Syph. 58:389, 1953.

[5]Garnetpaper, Carborundum Comp., Niagara Falls, N. Y.

[6]Monash, Samuel, and Rivera, Rafael M.: Formation of Milia Following Abrasion Treatment for Postacne Scarring. A.M.A. Arch. Dermat. & Syph. 68:589, 1953.

AUDIO-DIGEST OFFERS "TWO FOR THE MONEY"

Busy physicians have an opportunity to get "two for the price of one" in the form of postgraduate medical education and a chance to support the nation's medical schools. The American Medical Education Foundation recently. announced that a new source of funds now is available to medical schools through physician-support of the Audio-Digest Foundation. For a nominal weekly subscription fee, physicians receive from the Audio-Digest Foundation tape-recorded abstracts of current literature, lectures, etc., culled from current medical periodicals in all fields of medicine. This Foundation, organized by the California Medical Association, will turn over its profits to the AMEF.

State AMEF chairmen have been asked to support the national promotion of this new service as an additional means of raising funds for medical education. This should prove a tremendous boost to the AMEF's 1954 campaign drive for $2,000,000 from the medical profession to assist the country's seventy-nine approved medical schools.

Banthine Overdose In a Child

J. S. PENNEPACKER, M.D.
Sidney, Montana

SINCE the introduction of banthine, anticholinergic drugs have been widely prescribed for a variety of gastro-enterologic conditions. Clinically and experimentally, these drugs have proved to have a wide margin of safety. Although side effects are relatively common, serious poisoning has been found to be extremely rare. The accidental ingestion of banthine by children is probably discouraged by the unpleasant taste of the drug and the manufacturers state* that no cases of accidental poisoning have come to their attention. Therefore, it is felt that the reporting of such a case is of interest.

CASE REPORT

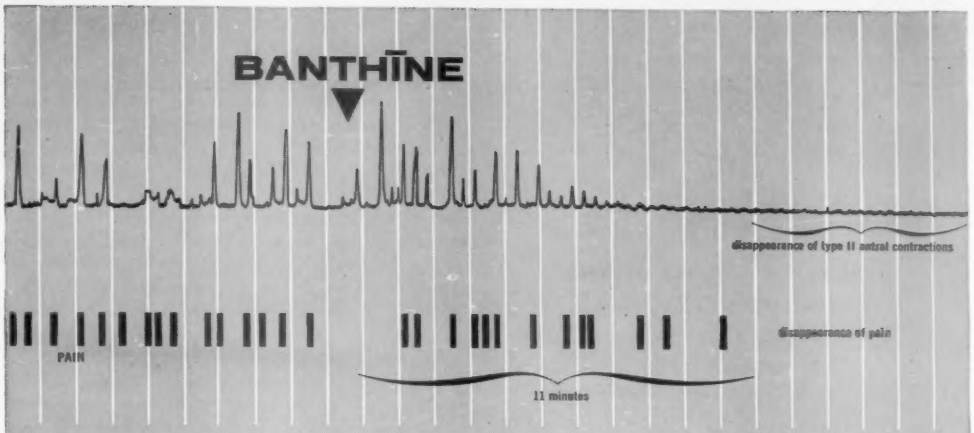
A male infant, aged 10 months, was seen May 17, 1953, for an upper respiratory infection complicated by otitis media. Treatment for this condition included the administration of flavored pediatric tablets of aspirin at four-six hour intervals as required for control of fever and pain. Oral penicillin was administered. The child seemed to be making a normal recovery.

On the evening of May 20, as he was a little restless and uncomfortable, the parents administered what they thought were two aspirin tablets at 7:30 p.m. and repeated them at 11:30 p.m. At midnight, I was called and advised that the child seemed to be developing a mottled red rash, which the mother, a registered nurse, thought might be due to a penicillin allergy. The baby was also restless and consequently was given one-half teaspoon (5 mg.) of elixir of benadryl. At 12:30 a.m. the parents called again and reported that they had discovered that instead of aspirin the child had accidentally been given two doses of two 50 mg. tablets of banthine, which the father was taking for peptic ulcer. At 12:50 a.m. the baby was first examined. There was marked flushing of the face and extremities and mottling of the rest of the body. The rectal temperature was 99.4, apical rate 170, and respirations 40. The patient appeared to be uncomfortable and slightly hyperactive. He had a very hoarse cry, the mucous membranes were extremely dry, and there was no salivation at all. The pupils were moderately dilated. At 1:00 a.m., he was given 0.2 c.c. of a 1:2,000 solution of prostigmin. At 1:25 a.m. the flushing was markedly decreased, his mouth moist, and the apical rate was 140. At 1:35 further improvement was apparent and the apical rate had decreased to 128. The child appeared much more comfortable but would not take fluids. The family was advised to use tepid sponges and to attempt to give him weak tea or water. At 4:00 a.m. the mother called and stated that the child again appeared to be flushed but seemed to be sleeping naturally so nothing further was done. At 8:30 a.m. she again called and stated that he was hoarse and that his mouth was dry again but that he did not appear very much flushed. The prostigmin was repeated in the same dosage, again with favorable results. At 1:00 p.m. another examination revealed dryness of the mouth and absence of salivation and there appeared to be very slight edema of both feet and suprapubic areas. Another 0.2 c.c. of prostigmin was given with rapid improvement. At 5:00 p.m. the child's mouth was still moist and he had started to eat. On the following day he was again examined. At this time the weight was 20 pounds, hemoglobin 11.1 gm., leukocyte count 15,250, temperature 100.4 by rectum, and physical and neurological examination completely normal. No subsequent ill effects have been noted.

*Van Antwerp, L. D.: Personal Communication.

Comment

A case of accidental ingestion of an overdose of banthine has been reported. The usual recommended dosage of this drug in a 150 pound adult is 100 mg. every six hours, or approximately 0.6 mg. per pound of body weight. In this case reported here, a 20 pound child received a total of 200 mg. within a period of four hours, a total dosage of 10 mg. per pound of body weight, or approximately 16 times the usual dosage. Moderately severe toxic symptoms persisted for nearly 18 hours. Partial relief was obtained by the periodic administration of prostigmin.



Effect of 100 mg. of Banthine administered orally on antral gastric motility and duodenal ulcer pain.[2]

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953

Banthīne® Reduces Hypermotility and Hyperacidity in Peptic Ulcer

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine® bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

National Affairs

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

103rd ANNUAL MEETING
June 21-25, 1954—San Francisco

Fee splitting, osteopathy, closed panel medical care plans, veterans' medical care and the training of foreign medical school graduates were among the major subjects of discussion and action during the sessions of the House of Delegates at the American Medical Association's 103rd Annual Meeting June 21-25 in San Francisco.

Named as President-Elect for the coming year was Dr. Elmer Hess of Erie, Pennsylvania, who, until his election, was serving as a member of the House of Delegates and as Chairman of the Council on Medical Service. Dr. Hess will become President of the American Medical Association at the June, 1955, meeting in Atlantic City, succeeding Dr. Walter B. Martin of Norfolk, Virginia. Dr. Martin took office at the Tuesday evening inaugural session in San Francisco's Palace Hotel.

The House of Delegates voted the 1954 Distinguished Service Award of the American Medical Association to Dr. William Wayne Babcock of Philadelphia for his outstanding contributions to medicine and humanity. Dr. Babcock, who was professor of surgery and clinical surgery at Temple University School of Medicine from 1903 to 1944, received the award from Dr. Martin at the Tuesday evening inaugural ceremony.

The final registration total for the San Francisco meeting was expected to reach approximately 35,000, including more than 12,000 physicians.

The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of a Judicial Council report on the subject of billing and made the additional recommendation "that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever, and that it further opposes any mechanism that encourages this practice."

The Judicial Council report included the following statements:

"The Judicial Council is of the opinion that the only new facet concerning this subject that has come up recently is the case of joint billing to some of the non-profit insurance companies. In many cases these insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical and all insurance plans which do not pay the individual physician in this manner should be urged to do so.

"The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills.

"There are cases, however, where the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fee charged should be paid directly to the individual physicians who rendered the services in question.

"Under no circumstances shall it be considered ethical for the physician to submit joint bills unless the patient specifically requests it and unless the services were actually rendered by the physicians as set out in the bill."

Four resolutions dealing with the osteopathic problem were considered. The House accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a Supplementary Report of the Board of Trustees on a Report of the Committee for the Study of Relations Between Osteopathy and Medicine:

"The justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations between Osteopathy and Medicine to visit schools of osteopathy for this purpose.

"The Conference Committee favorably recommended this proposal to the Board of Trustees of the American Osteopathic Association which considered it at a special meeting on February 6-7, 1954. It has referred the question to its House of Delegates which will act upon the proposal in July, 1954. If the action of the House of Delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year.

"The committee therefore recommends:

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

"Premarin" is an excellent preparation for the replacement of body estrogen. In "Premarin" all components of the complete equine estrogen-complex are meticulously preserved in their natural form. "Premarin" produces not only prompt symptomatic relief but a distinctive "sense of well-being" which is most gratifying to the patient.

1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

"PREMARIN."®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Estrogenic substances (water-soluble) also known as conjugated estrogens (equine)

Available in tablet and liquid form

has no odor . . . imparts no odor

NEW YORK, N. Y. Ayerst MONTREAL, CANADA

5410

"1. That no action be taken on the report at this time and that final action be deferred until December, 1954.

"2. That the committee be continued until December, 1954, in order to be available to evaluate education in schools of osteopathy should the House of Delegates of the American Osteopathic Association act favorably upon the recommendation of its Conference Committee."

The much-publicized New York resolution, calling for several changes in the Principles of Medical Ethics relative to participation in closed panel medical care plans, was considered by the Reference Committee on Miscellaneous Business. That committee made the following recommendation, which was adopted by the House:

"In the discussion before your Reference Committee on this resolution, it became apparent to the committee that clarification and interpretation of the Principles of Medical Ethics in relation to prepaid medical care plans are desirable. As set forth in the By-Laws, the Judicial Council has jurisdiction on all questions of medical ethics.

"Therefore, your Reference Committee recommends that the House of Delegates request the Judicial Council to . . . investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary, and report to the House of Delegates not later than the next annual meeting of the Association.

"The committee further recommends that the New York resolution be referred to the Judicial Council for consideration in connection with this investigation."

The New York resolution, among other suggested changes, would add the following new paragraph to Chapter I, Sec. 4, "Advertising," of the Principles of Medical Ethics:

"It should be understood that any medical care plan, company, or organization which advertises for subscribers and directs such subscribers to a restricted panel of physicians for medical care is advertising for the benefit of the physicians involved."

Accepting a report by the Reference Committee on Legislation and Public Relations, the House adopted two strong resolutions condemning the present practice of establishing service-connection for veterans' disabilities by legislative fiat. In recommending passage of both resolutions, the committee said:

"The study of the chronological expansion by law and regulation, together with evidence presented of pending legislation now before a Congressional Committee, emphasize all too clearly the imperative need of decisive action on the part of the American Medical Association.

"It is the opinion of the committee that the time is at hand when the American Medical Association and its component societies should go all out in preventing this unscientific method of determination of service-connected disabilities, and that we respectfully request that copies of these resolutions be transmitted to the Congress of the United States and other appropriate federal agencies."

In connection with veterans' medical care, the House also adopted recommendations by the Reference Committee on Insurance and Medical Service which reaffirmed the policy on non-service-connected disabilities, established at the 1953 annual meeting, and which commended the informational program carried out since then by the Committee on Federal Medical Services of the Council on Medical Service.

Three resolutions and a Board of Trustees supplementary report were submitted to the House regarding the evaluation of foreign medical school graduates, a subject which attracted major interest earlier this year at the annual Congress on Medical Education and Licensure in Chicago. The Reference Committee on Medical Education and Hospitals spent much of its time listening to the ideas and proposals of various state medical societies, state licensing boards, members of the Council on Medical Education and Hospitals and others. The Reference Committee recommended that "the intent and aims of this Supplementary Report and the three resolutions can best be met by referring the entire problem to the Council on Medical Education and Hospitals for further study. It is recommended that the Council report at the Interim Session in 1954 regarding the progress relative to this study." The House adopted the Reference Committee's recommendations.

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The report said that the standards and principles of the program will be maintained as guides and recommendations for all groups operating or establishing plans. The House, on recommendation of the Reference Committee on Insurance and Medical Service, adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans.

The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

Among a wide variety of other actions, the House also:

Voted to continue the holding of the annual Clinical Meetings;

MEMO: To Medical Profession

FROM: Clinical Research Dep't.
Hoffmann - La Roche Inc.

Dear Doctor:

Just a note to remind you briefly of a drug that can be of real help to you in relieving pain.

No matter which narcotic you are using at present, we believe you will find it worth while to try Levo-Dromoran 'Roche'...because it is distinguished by its relatively prolonged action...because it is less likely to produce constipation than morphine or other narcotics...because it is effective in very small doses (2 to 3 mg).

For patients with inoperable tumors, biliary or renal colic, myocardial infarction, trauma or other painful diseases, you will find Levo-Dromoran of definite value.

Sincerely,

Thomas C. Fleming

Thomas C. Fleming, M.D.
Department of Clinical Research

P. S. Levo-Dromoran® Tartrate (levorphan tartrate) can be given by mouth or by subcutaneous injection.

Speaking of analgesia —

WHICH NARCOTIC DO YOU PRESCRIBE?

No matter which one you've been using, we believe you will agree that most of them are reasonably good.

Still, we hope you'll try Levo-Dromoran 'Roche'...because it's less likely to produce constipation than morphine...because its action is usually more prolonged than that of morphine...because it's effective in very small doses -- 2 to 3 mg.

Approved the establishment of a program of medical military scholarships with appropriate safeguards limiting the number of students involved;

Approved the extension, on a voluntary basis, of the Medical Education for National Defense program which currently is in operation in five medical schools as a pilot study, and

Authorized the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at meetings of the Council, and asked for a report at the December meeting.

Highlights of the opening House session on Monday were selection of Dr. Babcock as recipient of the Distinguished Service Award and the addresses by Dr. Edward J. McCormick of Toledo, then President of the Association, and Dr. Martin, then President-Elect.

Dr. McCormick called upon the medical profession to take the guesswork out of medical costs by adopting average fee schedules on an area or regional basis. The Reference Committee on Reports of Officers later suggested that the Board of Trustees make a study of such programs where they already are in operation, and the House approved.

Dr. Martin, in his opening session address, declared that the most urgent problem before the medical profession is that of financing hospital services to make them more generally accessible. In his presidential inaugural address, Dr. Martin said that physicians are duty-bound to keep themselves informed on public matters affecting the medical welfare of the people, and he also urged doctors to "reach back farther than the disease" in treating their patients.

Two special citations were presented by the Association during the San Francisco meeting. During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallis, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M.D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline & French Laboratories of Philadelphia for "pioneering use of television in bettering the health of the nation." The plaque was accepted for the company by Mr. Francis Boyer, president.

The closing session also brought the announcement that the California Medical Association had presented a check for $100,000 to the American Medical Education Foundation.

The election at the closing session brought the following results, in addition to the selection of Dr. Hess as President-Elect:

Dr. Clark Bailey of Harlan, Kentucky, was named Vice President.

Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Texas, were re-elected to their positions on the Board of Trustees.

Also re-elected were Dr. George F. Lull of Chicago, Secretary; Dr. J. J. Moore of Chicago, Treasurer; Dr.James R. Reuling of Bayside, New York, Speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, Vice Speaker.

Dr. J. Morrison Hutcheson of Richmond, Virginia, was named by Dr. Martin as a member of the Judicial Council to succeed Dr. Edward R. Cunniffe of New York, who served as Council Chairman for many years. Dr. Homer Pearson of Miami, Florida, was elected new Chairman.

Dr. W. Andrew Bunten of Cheyenne, Wyoming, was elected a new member of the Council on Medical Education and Hospitals, succeeding Dr. W. L. Pressly of Due West, South Carolina. Dr. Charles T. Stone, Sr., of Galveston, Texas, was re-elected to the same Council. Both terms run to 1959.

Dr. Floyd S. Winslow of Rochester, New York, was re-elected to the Council on Constitution and By-Laws for a term ending in 1959.

Dr. Joseph D. McCarthy of Omaha, Nebraska, was re-elected to the Council on Medical Service for another term running to 1959. To fill the vacancy created on the same Council by Dr. Hess' resignation following his election as President-Elect, Dr. Robert L. Novy of Detroit, Michigan, was selected.

The House of Delegates also chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. Previously selected were Atlantic City for 1955 and Chicago for 1956. The dates of next year's meeting in Atlantic City are June 6-10.

GEORGE F. LULL, M.D.,
Secretary-General Manager,
American Medical Association.

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the college as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Ninth Annual Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, Illinois, October 18-22, 1954, and the Seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Hotel New Yorker, New York City, November 8-12, 1954.

These annual postgraduate courses endeavor to bring physicians up to date on recent advancements in the diagnosis and treatment of heart and lung diseases. Tuition for each course is $75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

GOVERNMENT BARS INTERSTATE SHIPMENT OF QUESTIONABLE "ELECTRICAL DEVICES"

Thirteen electrical devices which have been widely distributed for the diagnosis and treatment of serious diseases were barred from shipment in interstate commerce by an injunction decree entered today (March 16) in the Federal District Court at San Francisco.

The Electronic Medical Foundation of San Francisco consented to the entry of the decree, which is also binding upon the officers of the Foundation and all persons in active concert or participation with them.

The Food and Drug Administration, U. S. Department of Health, Education, and Welfare, which initiated the injunction suit, estimates that there are about 5,000 of the devices now in the offices of various fringe practitioners throughout the country. The names of the machines are as follows:

Oscilloclast

Oscillotron

Regular Push Button Shortwave Oscilloclast

Sweep Oscillotron

Sinusoidal Four-in-One Shortwave Oscillotron

Galvanic Five-in-One Shortwave Oscillotron

Depolaray

Depolatron

Depolaray Chair

Depolatron Chair

Depolaray Junior

Electropad

New Depolaray Junior

In addition to these machines the decree bans interstate shipment of "Blood Specimen Carriers" for use in a diagnostic machine, the Radioscope, which is maintained at the Foundation's offices in San Francisco. It also bans the shipment of any similar electrical devices for producing or measuring low-power radio waves or magnetic energy or any accessories or parts of such devices.

The Government charged that all the devices are misbranded, since they are not capable of diagnosing or curing any disease, much less the hundreds of serious diseases which it was claimed they will diagnose and treat effectively.

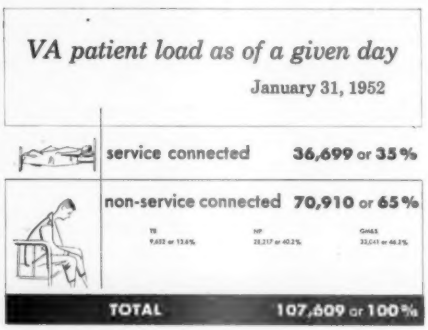
The Foundation, formerly the College of Electronic Medicine, was set up by the late Dr. Albert Abrams, inventor of the machines, to perpetuate his electro-medical theories. Fred J. Hart, president, has informed the Food and Drug Administration that research on the utility of the devices will be continued in Germany and Mexico, and that a magazine, "The Electronic Medical Digest," will continue to be published.

A.M.A. STUDIES HOUSEHOLD POISONING PROBLEM

Believing that "a stitch in time" saves lives, the A.M.A. Committee on Pesticides currently is undertaking a program designed to inform both physicians and the public on the uses and dangers of various drugs, chemical products and pesticides used around the home. The program was spearheaded by a recent committee proposal to organize a companion group under the Council on Pharmacy and Chemistry to delve more fully into the toxicologic effects of these products. In cooperation with the Committee on Pesticides, this new group will integrate its efforts with other medical agencies presently conducting studies on the health problems of household chemicals.

So far the committee has laid extensive groundwork by: (1) compiling lists of trade names and case histories of poisonings from these household chemicals; (2) developing criteria for evaluating the safety of toxic materials, and (3) preparing an exhibit, a radio transcription series and a pamphlet urging the public to guard against poisonings resulting from the use of various household chemicals.

In Viewing the VA Medical Program . . .



While the VA lists its patient load on a given day as 35% service-connected, only the long-range view of admissions and discharges over a year's time gives a truly accurate picture of the service-connected load (only 15.4%). This "discrepancy" appears because the VA's listing of 35% on a daily basis is not affected by the yearly turn-over of patients—the ratio of VA patients remaining to those treated and discharged (1 to 5.1). Over a period of a year, 84.6% of VA patients are treated for disabilities incurred after—and having no relationship to—military service.

The Geriatric Diet strikes a happy balance!

Your elderly patient may narrow down his food range to the point where foods high in protein, vitamins, and minerals are virtually eliminated. These ideas may help you show him how to enjoy a better-balanced diet.

These are essential —

Meat is as important now as ever. Fish steaks, chicken parts, chops, or cutlets can be bought in small portions. And adding skim milk powder to hamburger boosts both protein and calcium.

Plenty of fruits and vegetables mean adequate vitamins in proper balance. Chopped or strained vegetables and canned fruits are easy to chew. Salads need no cooking—but a sprig of parsley isn't enough.

Be sure the fluid intake is liberal. And remind your patient that it need not necessarily be water.

These are for fun —

Good company and a pretty plate make a happy combination. But if your patient eats alone, a tray in a sunny window makes all outdoors the guest.

A one-dish casserole gives free rein to the imagination and cuts down dishwashing. But perk up flavor with spices and herbs.

Beverages of moderate alcoholic content before dinner and at bedtime often aid appetite and may induce a better night's sleep.

The number of people over 60 is still on the upswing. And with proper attention to diet, these added years can be made more profitable and happy both for the elderly and their families.

United States Brewers Foundation

Beer—America's Beverage of Moderation

Sodium 17 mg, Calories 104/8 oz. glass
(AVERAGE OF AMERICAN BEERS)

If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Avenue, New York 16, N. Y.

POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO EVALUATION PHASE

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get vaccine.

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of necessary epidemiological information and laboratory specimens are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Gobulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

NUMBER OF PHYSICIANS IN U. S. REACHES ALL-TIME HIGH

The total number of physicians—218,522—licensed to practice in the United States set an all-time record in 1953. Official figures from the 52nd annual report on medical licensure of the A.M.A.'s Council on Medical Education and Hospitals indicate that 7,276 persons were added to the medical profession in 1953. During the same period, 3,421 physician deaths reported to the A.M.A. Headquarters gives a net increase of 3,855 in the physician population of the country. In 1952, an increase of 2,987 was reported.

The report appearing in the May 29 issue of the Journal of the American Medical Association shows that 14,434 medical licenses were issued in 1953 by the medical examining boards of the 48 states, the District of Columbia, Alaska, Canal Zone, Guam, Hawaii and Puerto Rico. Of this number, 6,565 were granted after written examination and 7,869 by reciprocity or endorsement of state licenses or the certificate of the National Board of Medical Examiners.

The present high level of medical education in this country is indicated by the fact that of the 5,646 graduates of approved medical schools in the United States to take examinations, only 3.8 per cent failed to pass. In comparison, however, of the 1,463 graduates of foreign medical faculties examined, 45.5 per cent failed.

Briefly, of the total number of physicians in the United States at the close of 1953—156,333 were engaged in private practice; 6,677 were in full-time research and teaching; 29,161 were interns or residents or physicians engaged in hospital administration; 9,311 were retired or not in practice, and 17,040 were in government service.

A.M.A. PRODUCES NEW RADIO SERIES—"35"

How to lead a healthy, happy life when you reach the half-way mark— 35 years of age—is the theme of a new radio transcription series prepared by A.M.A.'s Bureau of Health Education. Based on an article by Dr. Donald A. Dukelow of the Council's staff which appears in the July issue of "Today's Health" magazine, this series stresses the fact that, "Thirty-five is the half-way point—the time to check for defects before adding more mileage and more wear and tear to vital organs." Each of the 13 programs in the series covers a different area of concern to those who have reached this mark.

Emphasizing modern, preventive philosophy, each program topic is dramatized by a cast of outstanding actors and then discussed by a physician distinguished in his particular field.

The following subjects are included—heart disease, cancer, arthritis, high blood pressure, mental health, surgical advances, rehabilitation, preparation for old age, endocrinology, diseases of the blood, general therapeutics, nutrition, and diabetes.

The "Thirty-five—Mid-point of Life!" series will be available in July for distribution to state and county medical societies for airing over local radio stations.

AUXILIARY LAUNCHES "TODAY'S HEALTH" TEST

As a special test program of the national "Today's Health" Committee of the Woman's Auxiliary to the A.M.A. each physician and dentist in Virginia not now subscribing to the magazine will receive a six-month subscription for his reception room. The offer will begin with the July issue and run through December.

During the fall months, members of the local auxiliaries in the state will personally contact each physician and dentist to take subscription orders for next year. It is hoped that as a result of this test, "Today's Health" will win many new friends during the coming months both among patients and the professions.

FILM ON ALCOHOLISM ADDED TO A.M.A. MOTION PICTURE LIBRARY

Case studies of three types of alcoholics tracing the development of the disorder from origin are incorporated in a motion picture film which recently was added to the A.M.A.'s Motion Picture Library. Entitled "Alcoholism," this film attempts to show how the roots of this illness are imbedded personality difficulties often relating back to the formative years of the victim's childhood and how it can be treated through psychology. This black and white, sound, 22-minute film may be obtained from the Committee on Medical Motion Pictures for a service charge of two dollars.

NEW EXHIBIT ON SINUS TROUBLE

Persons in your home town suffering from clogged heads or draining noses will be especially interested in the new exhibit—"Sinus Trouble"—which the A.M.A. Bureau of Exhibits now is offering to state and county medical societies for local showings at fairs and similar public gatherings. Depicting the location of the sinuses, diagnostic procedures and latest treatments now followed by physicians, this exhibit is available for immediate bookings through the Bureau.

for greater safety in streptomycin therapy...

DISTRYCIN

Squibb Streptoduocin
Streptomycin and dihydrostreptomycin in equal parts

Distrycin has an important advantage over streptomycin. It has the same therapeutic effect but ototoxicity is greatly delayed. Since the patient is given only half as much of each form of streptomycin as he would have on a comparable regimen of either one prescribed separately, the danger of vestibular damage (from streptomycin) or cochlear damage (from dihydrostreptomycin) is significantly lessened.

Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.

Cat treated with streptomycin shows no nystagmus after whirling.

Cat given the same amount of Distrycin has normal reflex.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

SQUIBB

a leader in streptomycin research and manufacture

'Distrycin'® and 'Nydrazid'® are Squibb trademarks

Distrycin is supplied in 1 and 5 Gm. vials, expressed as base

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the Federal Government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread oposition developed. Then the committee chairman, Rep. Charles E. Wolverton (R.-N.J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health facilities for construction and equipment. This bill, however, was not supported by the administration.

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising, inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

Most other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. (Of the major bills, A.M.A. opposes only reinsurance.) Legislation to expand the Hill-Burton hospital construction program cleared what might have been a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnostic-treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Of the remaining legislation of interest to the medical profession, the status at this writing was about as follows:

The doctor draft amendment, to strengthen Defense Department's hand in dealing with physicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income. The long-dormant bill to transfer responsibility for Indians' health matters from the Indian Bureau in Interior Department to Public Health Service in the Department of Health, Education, and Welfare was pointed toward enactment, but might possibly be held up by objections of Senators from a few western states. The Interior Department had dropped its original objection.

The House-passed Social Security Bill, with the compulsory coverage of physicians eliminated, was before the Senate Finance Committee, where anything could happen. Two bills of medical interest already had been passed by both houses and signed into law. One prohibits the shipment of fireworks into a state where fireworks are illegal, and the other relieves Army medical officers of the technical responsibility for supervising preparation of food.

A reassuring note was sounded by President Eisenhower when he forwarded to Congress the controversial International Labor Organization convention on minimum standards of social security with a recommendation that it not be ratified. His message said most of the points—including a suggestion for socialized medicine—were not proper subjects for the Congress to deal with.

PROGRAM
EIGHTH ANNUAL ROCKY MOUNTAIN CANCER CONFERENCE
July 14 and 15, 1954
Shirley Savoy Hotel, Denver

WEDNESDAY, JULY 14

Morning

8:30—Registration, Lincoln Room Lobby.

9:45—Address of Welcome—John S. Bouslog, M.D., Denver, President, Colorado Division; American Cancer Society.

10:00—Symposium on Mucous Membrane Lesions—Harold D. Palmer, M.D., Denver, Presiding. Gerald B. Hurd, M.D., Cleveland; Paul Kotin, M.D., Los Angeles; John J. Conley, M.D., New York City; Earl D. Osborne, M.D., Buffalo, New York.

12:00—Adjourn.

Noon

12:15—Round Table Luncheon—Claude D. Bonham, M.D., Denver, President, Colorado State Medical Society, Presiding.

Afternoon

Samuel P. Newman, M.D., President-elect, Colorado State Medical Society, Presiding.

2:30—Tumors of the Large Intestine—Edwin H. Ellison, M.D., Columbus, Ohio.

3:00—Diagnosis and Treatment of Lung Carcinoma—Laurence L. Robbins, M.D., Boston.

3:30—Intermission.

3:45—Early Diagnosis and Treatment of Carcinoma of the Genito-Urinary Tract—Lloyd G. Lewis, M.D., Washington, D. C.

4:15—A Concept of Cancer—William Boyd, M.D., Vancouver, B.C., Canada.

4:45—Adjourn.

Evening

6:00—Social Hour.

7:00—Banquet (Informal)—Doctors and their ladies. Floor Show (no speaker), Lincoln Room, Shirley-Savoy Hotel.

THURSDAY, JULY 15

Morning

8:30—Registration, Lincoln Room Lobby.

10:00—Symposium on What and When to Biopsy—Frederick H. Brandenburg, M.D., Denver, Presiding. William Boyd, M.D., Vancouver, B.C., Canada; Edwin H. Ellison, M.D., Columbus, Ohio; Laurence L. Robbins, M.D., Boston; Lloyd G. Lewis, M.D., Washington, D. C.

12:00—Adjourn.

Noon

12:15—Round Table Luncheon—Carl A. McLauthlin, M.D., Denver, President, Denver Medical Society, Presiding.

Afternoon

Frank C. Campbell, M.D., Denver, Chairman, Cancer Control Committee of the Colorado State Medical Society, Presiding

2:30—The Problem of Bleeding in Menopausal Years—Gerald B. Hurd, M.D., Cleveland.

3:00—Differential Diagnosis and Treatment of Skin Cancer—Earl D. Osborne, M.D., Buffalo, New York.

thoroughbred

Only a long and celebrated ancestry can produce a champion racing thoroughbred.

Only **audivox** in the hearing aid field can trace an ancestry that includes both Western Electric and Bell Telephone Laboratories. **audivox** lineage springs from the pioneer experiments of Dr. Alexander Graham Bell, which were furthered by the development of the hearing aid at Bell Telephone Laboratories, and in turn, brought to fruition by Western Electric and **audivox** engineers.

Distinctly a thoroughbred in its field, **audivox** , successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nationwide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

TO THE DOCTOR: Send your patient with a hearing problem to a career Audivox and Micronic dealer, chosen for his interest, integrity and ability. There is such an Audivox dealer in every major city from coast to coast.

Audivox new all-transistor model 71 hearing aid

Alexander Graham Bell

audivox

Successor to *Western Electric* Hearing Aid Division

123 Worcester St., Boston, Mass.

The Thoroughbred Hearing Aid

3:30—Intermission.
3:45—Surgical Treatment of Tumors of the Parotid Gland—John P. Conley, M.D., New York City.
4:15—Cancer of the Lung in Relation to Smoking, Air Pollution, and Environmental Factors—Paul Kotin, M.D., Los Angeles.
4:45—Adjourn.

GUEST SPEAKERS

Gerald B. Hurd, M.D.
Cleveland, Ohio

Director of the Division of Obstetrics and Gynecology; Head of the Department of Gynecology, and Consultant in Gynecological Pathology, Saint Luke's Hospital, Cleveland, Ohio. Graduate of Johns Hopkins Medical School, 1928. Diplomate of American Board of Obstetrics and Gynecology, 1941; Founding Fellow, American Academy of Obstetrics and Gynecology. President, Cleveland Society of Obstetrics and Gynecology, 1953.

Paul Kotin, M.D.
Los Angeles, Calif.

Assistant Professor of Pathology, University of Southern California, School of Medicine; Attending Pathologist, Los Angeles County General Hospital. Graduate, University of Illinois School of Medicine, 1939. Diplomate American Board of Pathology; Fellow American Society of Clinical Pathologists. Member, American Association For Cancer Research; New York Academy of Sciences and California Society of Pathologists.

Laurence L. Robbins, M.D.
Boston, Massachusetts

Assistant Clinical Professor of Radiology, Harvard Medical School; Radiologist-in-Chief, Massachusetts General Hospital. Member, American College of Radiology; American Roentgen Ray Society; New England Roentgen Ray Society; Radiological Society of North America.

John J. Conley, M.D.
New York City, N.Y.

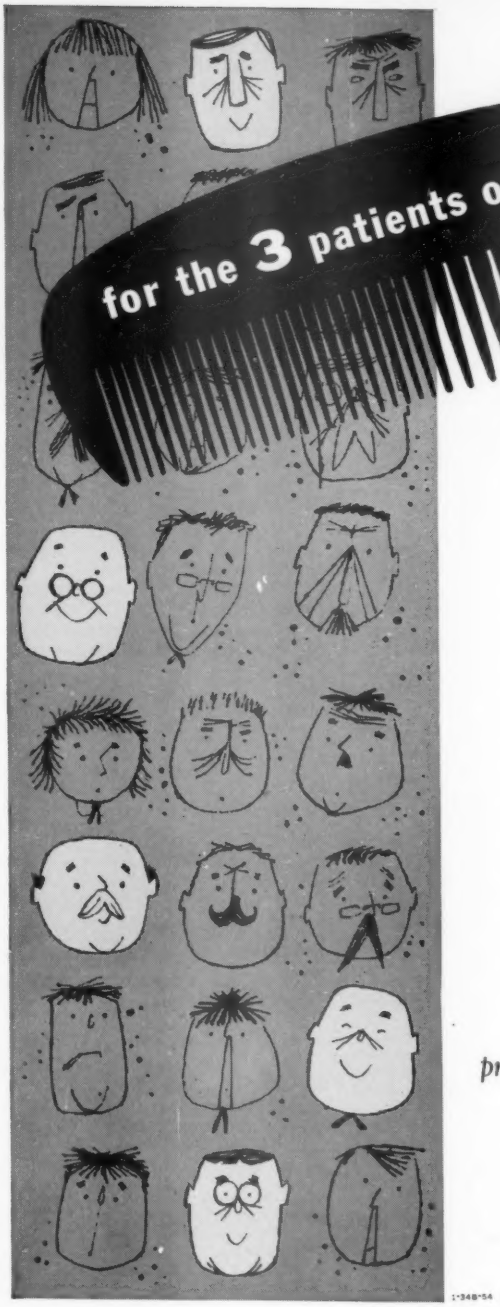
Chief, Head and Neck Department, Pack Medical Group, New York City; Chief, Head and Neck Service, St. Vincent's Hospital, New York City; Clinical Professor of Otorhinolaryngology, New York University; Graduate, University of Pittsburgh Medical School, 1937; Diplomate, American Board of Otolaryngology; Fellow, Triological Society; American College of Surgeons; New York Academy of Medicine; Secretary, 1952 and 1953, New York Cancer Society.

Lloyd G. Lewis, M.D.
Washington, D. C.

Professor of Urology and Chief of the Section on Urology, Georgetown University School of Medicine; Chief of Urological Service, Gallinger Municipal Hospital, Washington, D.C.; Consultant in Urology, Walter Reed Army Hospital and Bolling Field Air Force Hospital, Washington, D.C.; Graduate, Johns Hopkins University School of Medicine, Baltimore, 1928. Formerly Associate Professor of Urology, Johns Hopkins University School of Medicine; Chief of Urological Service, Walter Reed General Hospital; Certified by the American Board of Urology; Chairman of Visual Aids Committee, American Urological Association.

William Boyd, M.D.
Vancouver, B.C., Canada

Professor and Head of the Dept. of Pathology, University of British Columbia, Vancouver, B. C.; formerly Professor of Pathology and Bacteriology, University of Toronto. One of the founding members of the National Cancer Institute as well as a past President of that body. Also past President of the American Association of Pathologists and Bacteriologists and the International Association of Medical Museums. Author of several textbooks, including Textbook of Pathology, Surgical Pathology and Pathology of Internal Diseases.



for the 3 patients out of 4

who have seborrheic dermatitis of the scalp

For the scalp-scratchers, shoulder-brushers and comb-clutterers, there's welcome relief with SELSUN Sulfide Suspension.

Published reports on more than 400 cases[1-3] show that SELSUN completely controls seborrheic dermatitis in 81 to 87 percent of all cases, and in 92 to 95 percent of common dandruff cases. It keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

SELSUN is remarkably simple to use. Your patients apply it and rinse it out while washing the hair. It takes little time. No complicated procedures or messy ointments. Ethically advertised and dispensed only on prescription. In 4-fluidounce bottles with complete directions on the label. Abbott

prescribe...

SELSUN®

SULFIDE *Suspension*

(SELENIUM SULFIDE, ABBOTT)

1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), ibid., 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

1-348-54

Earl D. Osborne, M.D.
Buffalo, New York

Professor of Dermatology and Syphilogy at University of Buffalo School of Medicine; Chief Attending Dermatologist and Syphilogist at the Buffalo General Hospital, Meyer Memorial Hospital and Children's Hospital; Graduate, University of Michigan, 1919. One of the founders of the American Academy of Dermatology and Syphilogy in 1937 and for twelve years was Secretary and Secretary-Treasurer of this organization; President in 1950. In 1949, the Academy established the Earl D. Osborne Fellowship in Dermal Pathology at Armed Forces Institute of Pathology in Washington in recognition of his efforts in its organization and development. President of the American Dermatological Association since 1952. Author of more than fifty scientific publications.

Edwin H. Ellison, M.D.
Columbus, Ohio

Associate Professor, Department of Surgery, Ohio State University; Attending Surgeon, Ohio State University Hospital. Graduate, Ohio State University Medical School, 1943. Fellow, American College of Surgeons; Member, Society for University Surgeons; Surgical Biology Club; Columbus Surgical Society; Program Committee, Columbus Academy of Medicine.

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society. announce as the subject for this year's dissertation "Modern Developments in Anesthesia." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $250 is offered.

For complete information regarding the regulations, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Colorado

CORRECTIONS

Since the publication and distribution of the annual Directory of Physicians in May, some corrections have been received in the office of the Colorado State Medical Society and are being printed in this Journal for your information.

Please correct your Directory as follows:

Medical Representatives' Society

Correct Smith Dorsey Div. Wander Corp. to read SCHENLEY LABS.

Correct Ayerst, McKenna, and Harrison to read AYERST LABORATORIES.

Denver, Colorado

Correct Westwood telephone exchanges to read WEST; correct Emerson telephone exchanges to read EMPIRE.

Chambers, W. W., M.D.—correct telephone number to read WEST 4-3582.

Howry, Douglas, M.D.—correct to read **Howry, Douglass.**

Sherberg, B. C., M.D.—correct telephone number to read SPruce 7-2689.

Weeks, Paul R., M.D.—correct telephone number to read MAin 3-7147.

Yegge, W. Bernard, M.D.—correct to read MAin 3-6168; Denver 2; I*

Billings, Montana

Gibbs, Edward W., M.D.—correct specialty to read S* and delete Field of Practice.

Kalispell, Montana

Wallner, Alfred, M.D.—correct specialty to read S*.

Salt Lake City, Utah

Clawson, Thomas A., Jr., M.D.—correct telephone number to read 22-3470.

Evans, Joseph R., M.D.—correct telephone number to read 22-3470, and list specialty as I*.

Vernal, Utah

Delafield—correct to read Robert H.; 75 West Main; Vernal 576; S(PP).

HAVE YOU MADE YOUR RESERVATION?

The time has come once again to remind our readers of the Eighty-Fourth Annual Session of the Colorado State Medical Society to be held September 21 to 24 at the Broadmoor Hotel in Colorado Springs.

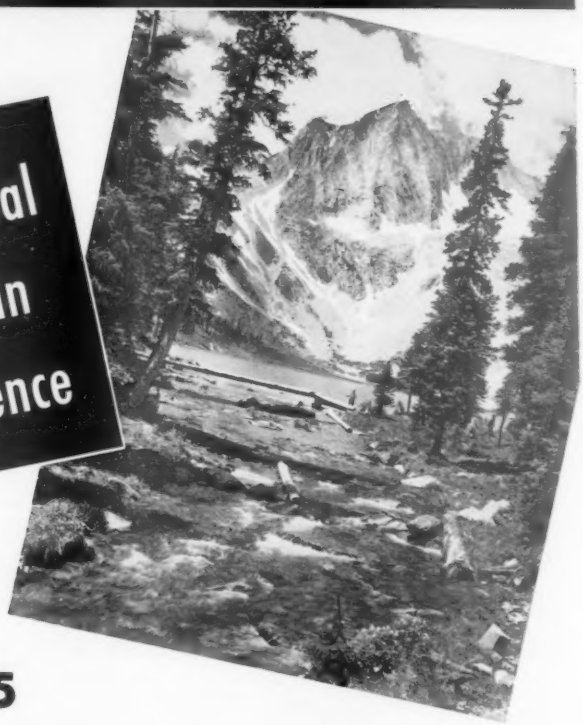
An interesting program has been planned with nationally acclaimed physicians slated to appear, as well as outstanding speakers in our own area. There will be many very fine exhibits both scientific and technical.

If you have not already made your advance hotel reservations for this meeting, we urge you to do so as soon as possible.

COLORFUL COLORADO

invites you to

The Eighth Annual Rocky Mountain Cancer Conference



at Denver
July 14 and 15

No Registration Fee • *Headquarters Hotel: Shirley-Savoy*

★ There will be an unusually fine program with eight outstanding guest speakers in Radiology, Dermatology, Surgery, Urology, Pathology, Internal Medicine and Gynecology.

★ You will enjoy meeting colleagues from 20 states who annually attend this superb conference.

★ A banquet and special entertainment the first evening will provide relaxation and enable you to enjoy Denver's western hospitality.

★ You can combine attendance at an interesting medical meeting with an enjoyable vacation in the Rocky Mountain West when scenery and climate are at their best.

For information write to
Rocky Mountain Cancer Conference
835 Republic Bldg., Denver 2

SPONSORED BY THE COLORADO STATE MEDICAL SOCIETY AND
THE COLORADO DIVISION, AMERICAN CANCER SOCIETY

Plan Now to Be in Denver July 14 and 15

SOUTHWESTERN SURGICAL CONGRESS HONORS DR. NICHOLAS A. MADLER

At the annual meeting of the Colorado members of the Southwestern Surgical Congress in Colorado Springs, Dr. Nicholas A. Madler was called to the rostrum to be presented with congratulations and a bouquet of flowers in recognition of his fifty years in the practice of medicine. Dr. George Bancroft made the formal presentation.

DR. MADLER

The Colorado Springs meeting fell on the same date as Dr. Madler's graduation from Rush Medical College in 1904. Dr. Madler interned at St. Mary's Hospital in Milwaukee, practiced in Mobile, Alabama, for twelve years, and came to Colorado, as did so many of our early important leaders in the profession, because of tuberculosis. He spent about a year as a patient in Colorado Springs hospitals, then entered practice in Greeley thirty-six years ago.

Dr. Madler has been President of his Weld County Society, was Chief of Surgical Service of the Weld County Hospital for twelve years, was President of the Colorado State Medical Society in 1934-1935, had the tough assignment as a member of our first Board of Supervisors, and he became the second chairman of our Colorado State Society's Board of Supervisors. Dr. Madler is a Fellow of the American College of Surgeons and has for many years served on important committee assignments with the college. He is also a Fellow of the Southwestern Surgical Congress.

Dr. Madler has made an outstanding contribution to the recipients of medical care in Weld County and to the work of organized medicine in the State of Colorado.

E. H. MUNRO, M.D.

Obituaries

EARL DUANE McGILL

Dr. McGill died May 3, 1954, at his home in Mesa, Arizona, following a heart attack. He had moved to California in 1949 and to Mesa in 1954 after retiring from fifty years of practice in Denver. He was one of Denver's leading surgeons.

Dr. McGill was born in 1873 at Grand Blanc, Michigan. In 1897 he graduated from the University of Colorado Medical School. He was a member of the State Board of Medical Examiners in 1900 and served one term in the State Legislature. Later in his career, he was a member of the State Board of Health.

Dr. McGill established hospitals at Blue Hill, Nebraska, and at Clyde, Kansas. He was a life member of the Colorado State Medical Society, an ex-President of the Denver County Medical Society and a member of the Surgeons' Club, Rochester, Minnesota.

Dr. McGill is survived by his widow, Almira, two sons, a daughter, eleven grandchildren and four great grandchildren.

EARLE HARRISON CORRY

Dr. Earle Corry of Pueblo died May 18, 1954, at Corwin Hospital after a long illness. He was born in La Crosse, Wisconsin, in 1890 and graduated from Milwaukee Medical College. In 1924 he came to Pueblo where he specialized in dermatology and served on the staff of Corwin Hospital until his retirement in 1951. He was a former chief of staff of that institution.

Dr. Corry was an emeritus life member of the Colorado State Medical Society. He is survived by his widow, Genevieve, a son and a daughter.

VIRGIL J. JERNIGAN

Dr. Virgil Jernigan died on May 11, 1954, after a long illness. He was born in 1868 in Tennessee and attended school in that state, graduating from Vanderbilt University School of Medicine in 1900. In 1914 he started his practice in Longmont, Colorado. Dr. Jernigan was Boulder County health officer for some years, Past President of the Boulder County Medical Society, and an emeritus life member of the Colorado State Medical Society.

Surviving Dr. Jernigan are his widow, three sons and a daughter. The family home is at 1009 3rd Avenue, Longmont, Colorado.

WILLIAM C. HOWELL

Dr. William C. Howell of Colorado Springs died on June 1, 1954, following an illness of several years. Dr. Howell was born November 13, 1887, in Dothan, Alabama, where he eventually practiced following his years of education, which culminated in a medical degree received in 1908 from the Atlanta College of Physicians and Surgeons, now the Emory University Medical School.

In 1918 Dr. Howell came to Colorado for his health, and by 1921 was able to take his medical license in this state, and he practiced in Colorado Springs until shortly before his death. He was a member of the American Medical Association and of the El Paso County Medical Society, of which he served as Secretary from 1944 to 1947. Dr. Howell is survived by his widow and two children.

Component Societies

NORTHEAST COLORADO

The Northeast Colorado Medical Society elected its new officers at the May meeting. Under Northeast's officer-elect system, all officers are elected in May and assume their new duties on the first of September. The new officers will be: Dr. Carl J. Manganaro, Sterling, President; Dr. Doris M. Benes, Haxtun, Vice President; Dr. J. W. McDonald, Sterling, Secretary, and Dr. R. J. Groeger, Sterling, Treasurer. At this annual meeting of the Society Drs. Claude D. Bonham, President, and Lawrence D. Buchanan, Vice President, respectively, of the State Society were guest speakers. The dinner meeting at the Sterling Country Club was preceded by a social hour at the home of Dr. and Mrs. Kenneth H. Beebe.

OTERO COUNTY

The regular meeting of the Otero County Medical Society, held May 20 at La Junta, included a scientific program and the annual election of officers. Drs. W. B. Yegge and J. Philip Clarke of Denver presented a symposium on the diagnosis and treatment of arthritis. Dr. William R. Sisson of La Junta was elected President of the County Society for the coming year. Dr. R. Sherwin Johnston, who is also the Society's health advisor, was elected Vice President, and Dr. Elmer L. Morgan of Rocky Ford was elected Secretary-Treasurer.

MORGAN COUNTY

The mutual problems of medicine and pharmacy were discussed informally and at length at the May meeting of the Morgan County Medical Society, which was given over entirely to this project in lieu of a scientific program. The meeting was held May 4 at the Fort Morgan Country Club.

SAN LUIS VALLEY

A program on the activities and finances of the State Medical Society was given at the regular meeting of the San Luis Valley Medical Society, held in Monte Vista. Dr. Claude D. Bonham, President, and Mr. Harvey T. Sethman, Executive Secretary, were the guest speakers, both from Denver. The meeting was held in the offices of Dr. Clement F. Knobbe just before he closed his offices to undertake a year of postgraduate study.

WELD

The regular meeting of the Weld County Medical Society was held on June 7, 1954, at 7:30 p.m. at the Weld County General Hospital. A very fine paper was presented by C. Steward Gillmor, M.D., of the Arthritis and Rheumatism Foundation, Kansas City, Missouri, on "The Shoulder Hand Syndrome."

The next meeting has been scheduled for September 13, 1954, at the Weld County General Hospital in Greeley.

An honorary dinner was given by the Weld County Medical Society on June 2, 1954, at the Greeley Country Club, for those of the Weld County Society who have completed fifty or more years of medical practice. Those honored were Drs. Charles B. Dyde, Ella A. Mead, Nicholas A. Madler, all of Greeley, and Dr. George A. Nelson of Windsor. Guests of the Society were Drs. Claude D. Bonham, Irvin E. Hendryson, C. F. Kemper, Frank E. Rogers, T. Leon Howard and Frank B. McGlone, all of Denver. Certificates of service were also presented.

NEW GROUP ORGANIZED BY DOCTORS' WIVES

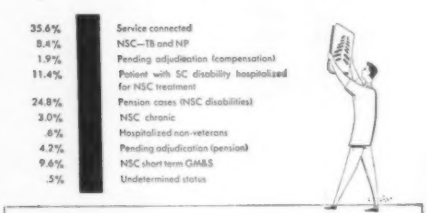
A new group, The Auxiliary of the American Medical Association of Doctors' Wives, was recently organized in San Luis Valley by doctors' wives in that district with the help of Mrs. Grow of Denver.

Their first meeting was held in Monte Vista, Wednesday, May 26, at the Boiler Cafe with Mrs. Robert B. Bradshaw acting as chairman pro tem.

The following officers were elected: Mrs. William W. McKinley, Jr., Monte Vista, President; Mrs. John W. Haskin, Center, Vice President; Mrs. Roy J. Day, Alamosa, Secretary; Mrs. Littleton J. Bunch, Alamosa, Treasurer; Mrs. George R. Davis, Antonito, Corresponding Secretary; Mrs. Fred A. Rechnitz, Alamosa, Publicity Chairman; Mrs. Robert B. Bradshaw, Alamosa, Membership Chairman; Mrs. Charles M. Worth, Center, Ways and Means Chairman; Mrs. David D. Strong, Alamosa, Today's Health Chairman; Mrs. Howard M. Rupp, Health and Education Chairman. A committee to organize the By-Laws was appointed.

The next meeting has been scheduled to be held on June 9 at the home of their President, Mrs. McKinley of Monte Vista.

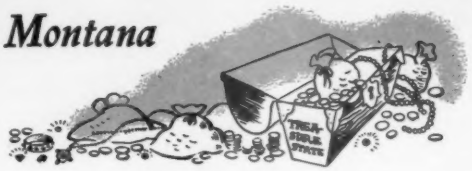
In Viewing the VA Medical Program . . .



VA explanation of patient load on a given day

The above classification is presented by the VA as an explanation of the large non-service-connected patient load in its hospitals. The medical profession recommends that only the first category and those in the third whose disabilities are determined to be service-connected should be entitled to federal medical care. Non-service-connected TB and NP cases should continue to be treated on a temporary basis until community and state facilities can be readied. The remaining groups obviously have no service-connection and are hospitalized for illnesses or injuries incurred in civilian life.

Montana



PRELIMINARY PROGRAM
MONTANA MEDICAL ASSOCIATION

Butte; September 16-19, 1954

The 76th Annual Meeting of the Montana Medical Association will be held in Butte, Montana, September 16-19, 1954. The scientific sessions of the meeting have been scheduled on Thursday and Friday, September 16 and 17, and the sessions of the House of Delegates on Saturday and Sunday, September 18 and 19.

The guest speakers at this meeting will include:

J. H. Randall, M.D., Professor and Head of Obstetrics and Gynecology, State University of Iowa—

1. "Toxemias of Pregnancy."
2. "Caesarean Section."

Carroll B. Larson, M.D., Professor and Head of Orthopedic Surgery, State University of Iowa—

1. "Traumatic Joints."
2. "Intra-medullary Nailing."

Rubin Flocks, M.D., Professor and Head of Urology, State University of Iowa—

1. "Carcinoma of the Prostate—Use of Radioactive Gold."
2. "The Management of Urinary Calculi."

Willis M. Fowler, M.D., Professor of Internal Medicine, State University of Iowa—

1. "Blood Diseases—Leukemia and Related Diseases."
2. "Medical Treatment of Thyroid Disease and the Use of Radioactive Iodine."

Robert T. Tidrick, M.D., Professor and Head of Department of General Surgery, State University of Iowa—

1. "The Nutrition of the Surgical Patient Before and After Surgery."
2. "Problems in Pediatric Surgery."

Charley J. Smyth, M.D., Director of Graduate and Postgraduate Education, University of Colorado School of Medicine, Denver—

1. "The Current Therapy of Gout."

The Program Committee, under the Chairmanship of T. W. Saam, M.D., Butte, has arranged to present two clinical-pathological conferences. The first conference will be presented at 1:30 p.m. on Thursday, September 16. E. C. Segard, M.D., Billings, will serve as moderator of this conference. The other participants are Mabel E. Tuchscherer, M.D., John S. Gilson, M.D., and Walter B. Cox, M.D. The second conference will be held at 4:10 p.m. on Friday, September 17. John A. Newman, M.D., Butte, will serve as moderator of this conference. The other participants are Deane C. Epler, M.D., Elizabeth Grimm, M.D., and George T. R. Fahlund, M.D.

On Thursday evening, September 16, the association will hold its annual reception and banquet. Mr. Palmer Hoyt, Editor of the Denver Post, will present the principal address of this banquet. In addition, those physicians who have been in the active practice of medicine fifty years or more will be honored.

On Friday evening, September 17, the Silver Bow County Medical Society, which is host to the Montana Medical Association, will sponsor an informal reception for members and guests.

The final program of this meeting will be available for distribution about August 1. The office of the Montana Medical Association will be glad to mail a copy of this program to any physician in the Rocky Mountain area upon request.

The Biggest Meeting In Wyoming History

The fifty-first Annual Meeting of the Wyoming State Medical Society is now history, and made history. The sessions at Sheridan June 7 to 9 attracted far and away the largest registration in the history of Wyoming's state meetings. A total of 142 Doctors of Medicine attended. Exhibitors, members of allied professions and lay guests added another 60, and 77 members of the Woman's Auxiliary registered. The almost-300 total even taxed Sheridan's hotels and motels.

The scientific program was of a caliber fitting the large attendance, and it is hoped that many of the presentations can be presented through the columns of this Journal within the next twelve months.

Dr. Russell I. Williams of Cheyenne was chosen President-elect at the last of the four meetings of the House of Delegates and next year will succeed Dr. B. J. Sullivan of Laramie, who was installed last month upon the retirement of Dr. James W. Sampson of Sheridan from the presidency. Other new officers elected include Dr. Joseph S. Hellewell of Evanston, Vice President; Dr. Harlan B. Anderson of Casper, Secretary; Dr. Carleton D. Anton of Sheridan, Treasurer, and Drs. J. E. Hoadley of Gilette and Francis A. Barrett of Cheyenne, Councilors for three-year terms. Dr. W. Andrew Bunten of Cheyenne and Dr. Albert T. Sudman of Green River were re-elected to two-year terms as Delegate and Alternate, respectively, to the American Medical Association.

Dr. DeWitt Dominick of Cody, a recent Past President of the Society, was chosen as Scientific Editor for Wyoming of the Rocky Mountain Medical Journal to succeed Dr. Franklin D. Yoder of Cheyenne.

Health is everybody's business. Optimal health is not an inalienable right and privilege of the individual that comes automatically. The health of the individual must be actively worked for, and the health of the community must be carefully planned, developed, and nurtured. The health program must consider the entire community.—Vlado A. Getting, M.D., J.A.M.A., September 26, 1953.

Obituary

WILLIAM L. HAMILTON

Dr. William L. Hamilton, 74, died of a heart attack while on vacation in California, on June 10, 1954.

Dr. Hamilton was graduated from Hahnemann Medical College, Philadelphia, Pennsylvania, in 1903. He practiced in Malvern, Pennsylvania, until 1943, at which time he moved to Santa Fe, New Mexico, where he planned to spend the remainder of his life in retirement. However, due to the shortage of doctors during the war, he opened an office and began practicing medicine, and continued until his death.

He had been honored by the New Mexico Medical Society for having praticed medicine for fifty years.

Dr. Hamilton was a member of the Santa Fe County Medical Society, New Mexico Medical Society and the American Medical Association.

In Viewing the VA Medical Program . . .

we are not talking about...

1. VA Form 10-P-10
2. Ability of veterans to pay
3. Efficiency of VA Administration
4. Extent of abuse

The medical profession is not concerned with alleged maladministration of present legislation by the Veterans Administration or with abuses by veteran-applicants of the hospital and medical care privileges. The nation's physicians do not feel that they have the responsibility to police the veterans medical care program, although they have cooperated wholeheartedly in assuring that veterans hospitalized under the present VA laws receive the highest quality of medical care.

Utah Honors Medical Writer

The Utah Medical Association recently awarded a plaque to Mr. William G. Patrick, medical editor of the Salt Lake Tribune, recognizing his contribution through ten years of medical writing for the public benefit. The award was made to Mr. Patrick and the Tribune for "your outstanding contribution to the advancement of medicine in Utah and meritorius service to the people of the state of Utah." It was signed by Dr. Frank K. Bartlett, Ogden, Association President; Dr. Homer E. Smith, Salt Lake City, Secretary, and Dr. J. Rex Miller, Salt Lake City, Treasurer.

MEETING OF UTAH CHAPTER A.A.G.P. SCHEDULED

The Fourth Annual Scientific Meeting of the Utah Academy of General Practice has been set for September 9 and 10, 1954, at the Hotel Utah, in Salt Lake City. An excellent two-day symposium on ObGyn has been planned.

Reservations may be made directly to the Hotel Utah in Salt Lake City or to J. Poulson Hunter, M.D., Secretary-Treasurer, Utah Academy of General Practice, 3007 Highland Drive, Salt Lake City 6, Utah.

Obituary

EDWIN R. MURPHY

Dr. Edwin R. Murphy, 72, the first physician in Utah to devote his practice exclusively to pediatrics, died in a Salt Lake City hospital of a coronary occlusion. He had actively practiced in Salt Lake City from 1924 until his death. His determination to become a children's specialist resulted from the death at an early age of his son, just prior to World War I.

He married Bess Bryan Woodcock in Denver in 1909, and went to Clear Creek, Carbon County, to conduct a general practice and serve as health officer for the Utah Fuel Co. There he remained until he enlisted in the Medical Corps of the U. S. Army for the duration of World War I.

Immediately following the war, he returned briefly to general practice in Winter Quarters, Carbon County, and then went to Philadelphia and later New Orleans while he pursued at Pennsylvania and Tulane Medical Colleges the study of the specialty he was to practice for thirty years.

Dr. Murphy was born in 1882 in Champaign, Illinois. He received his first medical diploma at Rush University, Chicago.

He was a Fellow of the American Academy of Pediatrics and a member of the American Board of Pediatrics, the Intermountain Pediatrics Association, the Salt Lake County and the Utah State Medical Associations. He was President of the County Society in 1944. The Intermountain Pediatrics Association in 1952 established in recognition of his work the annual E. R. Murphy Memorial Lectureship.

UTAH STATE

At a recent meeting of the Woman's Auxiliary to the Utah State Medical Association, the following officers for the 1954-1955 year were elected:

State President: Mrs. C. O'Neal Rich.
President-elect: Mrs. Elmo E. Eddington.
Immediate Past President: Mrs. A. M. Okelberry.

First Vice President: Mrs. E. D. Zeman.
Second Vice President: Mrs. R. N. Malouf.
Recording Secretary: Mrs. Joseph H. Allen.
Corresponding Secretary: Mrs. James F. Orme.
Treasurer: Mrs. R. W. Sonntag.
Auditor: Mrs. R. H. Wakefield.
Historian: Mrs. Thomas Feeny.
Parliamentarian: Mrs. Glen F. Harding.

Standing Committees

Archives and Biographies: Mrs. Earl H. Philips, Salt Lake City.

Benevolent Memorial: Mrs. Emery M. Argyle, Salt Lake City.

Secretary and Treasurer: Mrs. A. James McCallister, Salt Lake City.

Courtesy: Mrs. Vernal Johnson, Ogden.

Finance and Budget: Mrs. William Sevy, Salt Lake City.

Legislation: Mrs. Noull Z. Taner, Layton.

Mental Health: Mrs. James Webster, Provo.

News Bulletin Editor: Mrs. Robert R. Robinson, Salt Lake City.

Associate Editor: Mrs. Milton Newman, Salt Lake City.

Nurse Recruitmant: Mrs. Marian B. Noyes, Salt Lake City.

Organization: Mrs. Elmo Eddington, Lehi.

Press and Publicity: Mrs. Morgan S. Coombs, Salt Lake City.

Program: Mrs. Rieley G. Clark, Provo.

Public Relations: Mrs. Roy A. Darke, Salt Lake City.

Revisions: Mrs. William Barratt, Helper.

Today's Health: Mrs. Wesley L. Bayles, Salt Lake City.

Bulletin: Mrs. G. S. Francis, Wellsville.

Civilian Defense: Mrs. R. N. Hirst, Ogden.

News Notes

Wesley E. Peltzer, M.D., of Salt Lake City, was elected President of the Utah Heart Association at the annual meeting recently held at the Salt Lake General Hospital, succeeding Irving Ershler, M.D., of Salt Lake City.

M. M. Wintrobe, M.D., Professor of Medicine, and Thomas F. Dougherty, M.D., Professor of Anatomy, University of Utah College of Medicine, received two of eight grants made by the National Cancer Institute to support nation-wide efforts to find chemical agents effective in treatment of cancer.

* * *

T. R. Seager, M.D., has been elected President of the Chamber of Commerce of Vernal, Utah. Dr. Seager has been active in community affairs since 1946, when he entered practice in Vernal, as well as in his county and state medical societies.

* * *

Leo T. Samuels, M.D., professor of biochemistry, University of Utah College of Medicine, will visit German universities this summer as one of a team of nine medical scientists who will participate in seminars on hormone therapy. The tour is sponsored by the Unitarian Service Committee of Boston.

* * *

Dr. John Z. Bowers, Dean of the University of Utah College of Medicine and Head of the Radiobiology Laboratory, has announced the allocation of $185,368 by the Atomic Energy Commission to continue the work of the Radiobiology Laboratory for its fourth year.

* * *

M. M. Wintrobe, M.D., Professor of Medicine, University of Utah College of Medicine, was moderator of a discussion on thrombocytopenia at a conference on hemorrhagic diseases held in May at Marquette University, Milwaukee.

* * *

Milo C. Moody, M.D., Spanish Fork, Utah, has been named President of the newly organized Utah County Chapter of the Utah Academy of General Practice. Boyd J. Larsen, M.D., of Lehi, is acting as Secretary.

Medical School Notes

Medical Alumni Clinics and Banquet

Alumni of the University of Colorado School of Medicine held their annual clinics and banquet on June 4, 1954. The clinics consisted of case presentations by members of the Medical Center faculty and a series of scientific papers given by six alumni of the school, Dr. Oscar T. Clagett, Rochester, Minnesota, "Surgical Management of Mediastinal Tumors"; Dr. Joseph A. Bell, Bethesda, Maryland, "History of Pertussis Vaccination"; Dr. Douglass H. Howry, Denver, "Research on Application of Ultra-sonic Mechanical Waves to the Visualization of Tissue"; Dr. Milton T. Rees, Idaho Falls, "Diabetes From Diabetic Physician's Standpoint"; Dr. Harold J. Beck, Albuquerque, "Diagnosis of Kidney Tumors"; and Dr. William B. Millet, Denver, "Case Report on Arteritis."

The annual banquet was held at the Albany Hotel, at which time recognition medals were presented to the following faculty members who had served the School for twenty-five years: Elizabeth K. O'Toole, Dr. Maurice E. Marcove, Dr. Rex L. Murphy, Dr. Lumir R. Safarik and Dr. Hermann B. Stein. Also honored were the graduates of Colorado Medical Schools who have practiced for fifty years and the seniors of the school who were guests of the alumni. Dr. Gerald Frumess served as toastmaster for this eventful occasion.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel, Los Angeles, California, May 16-19, 1955.

For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.

THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

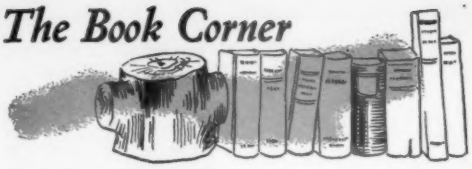
Applications for certification (American Board of Obstetrics and Gynecology) for the 1955 Part I Examinations are now being accepted. Candidates are urged to make such application sometime in July or August.

All candidates for admission to the examinations are required to submit, with their application, a plain typewritten list of all patients admitted to the hospitals where they practice for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathological diagnosis, nature of treatment, and end result.

Application for examination or re-examination, as well as requests for resubmission of case abstracts, must be made to the Office of the Secretary, American Board of Obstetrics and Gynecology, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio, prior to October 1, 1954.

Under a change of requirements for the Part I Examination, candidates must submit twenty case abstracts rather than twenty-five as formerly. Five of these may be from one's residency service.

The Book Corner



New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

The Atom Story: By J. G. Feinberg, Foreword by Prof. F. Soddy, F.R.S. In this book Dr. Feinberg tells in a simple and interesting manner the story of the atom for the benefit of the lay reader with little or no technical knowledge. He believes, with myself, that if properly presented the subject can be made intelligible to the ordinary man and that there is no subject at the present time of greater importance to him. This Foreword is just to wish him success in his effort, and to stress the vital importance of his topic. Price: $4.75.

Fifty Years of Medicine: By Lord Horder. An expanded version of the Harben Lectures delivered at the Royal Institute of Public Health and Hygiene, December, 1952. Price: $2.50.

A Manual of Tropical Medicine (Second Edition): By Thomas T. Mackie, M.D., Colonel, M.C., A.U.S. (Retired); Chairman, The American Foundation for Tropical Medicine. George W. Hunder, III, Ph.D., Colonel, M.S.C., U.S.A.; Chief, Section of Parasitology-Entomology, Fourth Army Area Medical Laboratory, Brooke Army Medical Center, Fort Sam Houston, Texas. C. Brooke Worth, M.D., Field Staff Member, Division of Medicine and Public Health, The Rockefeller Foundation. New, Second Edition; 907 pages with 304 illustrations, seven in color. Philadelphia and London: W. B. Saunders Company, 1954. Price: $12.00.

Fundamentals of Otolaryngology: A Textbook of Ear, Nose and Throat Diseases: By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology; Director of Division of Otolaryngology, University of Minnesota Medical School. New, Second Edition; 487 pages with 197 figures. Philadelphia and London: W. B. Saunders Company, 1954. Price: $7.00.

Illustrated Review of Fracture Treatment: By Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D. Attending Surgeon in Charge of Orthopedics, the New York Hospital; Attending Orthopedic Surgeon, Hospital for Special Surgery; Associate Professor of Clinical Surgery (Orthopedics), Cornell University Medical College.

Wine as Food and Medicine: By Salvatore P. Lucia, A.B., M.D., Sc.D., F.A.C.P. Professor of Medicine, University of California School of Medicine. Copyright, 1954, by The Blakiston Company, Inc. Price: $3.00.

Endemic Goiter, The Adaptation of Man to Iodine Deficiency: By Drs. John B. Stanbury, Gordon L. Brownell, Ph.D., Douglas S. Riggs, Hector Perinetti, Juan Itioz, Ph.D., and Enrique B. Del Castillo. Published by Harvard University Press, Cambridge, Mass. Copyright, 1954, by the President and Fellows of Harvard College. Price: $4.00.

Man Above Humanity, A History of Psychotherapy: By Walter Bromberg M.D., author of Crime and the Mind. Copyright, 1954, by J. B. Lippincott Company. Price: $5.75.

A Handbook of Resources Available to Physicians: By Iowa State Medical Society. Copyright, 1954, by the Iowa State Medical Society.

Beyond the Germ Theory, The Roles of Deprivation and Stress in Health and Disease: By Iago Galdston M.D. A New York Academy of Medicine Book. Published June 15, 1954, by Health Education Council, New York. Price: $4.00.

Peripheral Circulation in Man, A Ciba Foundation Symposium: By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch.; and Jessie S. Freeman, M.B., B.S., D.P.H., assisted by Joan Etherington. With 72 illustrations. Published by Little, Brown and Company, Boston. Price: $6.00.

Book Reviews

The Jealous Child: By Edward Podolsky. N. Y. Philosophical Society 1954. 147 pages. Price: $3.75.

Dr. Podolsky, with the Department of Psychiatry at King's County Hospital in Brooklyn, New York, is already known to both the medical profession and the laity for his previous works: "Medicine Marches On," "Music For Your Health," "Stop Worrying and Get Well," "You and Your Troubles," "Doctors, Drugs and Steel." In addition to these titles, Dr. Podolsky edited War Medicine, Encyclopedia of Abberrations and Music Therapy.

In his most recent work, Dr. Podolsky emphasizes that jealousy in children is generated by many circumstances: physical defects, ill health, economic and social conditions, emotional and mental deficiencies and immaturities. These causes in turn are examined, discussed and remedial measures are proposed which may be put to practical use by the parent, the teacher, the psychologist, and the social worker. The text proper is followed by an extensive bibliography which will be of use to those readers desiring to do more intensive work on this subject.

This title will probably find its best use the public library, the medical library, and the college or university library.

BARBARA HURLEY,
Librarian, Denver Medical Library.

Understanding the Japanese Mind: By James Clarke Moloney. N. Y. Philosophical Library, 1954. 252 pages. Price: $3.50.

In the Preface to his newest titles, "Understanding the Japanese Mind," Dr. Moloney explains to the reader the reason for the existence of his book. "The author's curiosity regarding the unusual qualities of the Japanese people was stimulated in 1940 by two visits to their islands, and his acquaintance with his professional counterparts in Japan. However, the original interest expanded to include the whole people."

Dr. Moloney's principal departure from the thinking of some previous writers on Japan is his conviction that the Japanese people are neither "mysterious," "inscrutable," nor "unpredictable," but are entirely reasonable, understandable and predictable, especially when one fully understands the restrictions which have been placed upon their behavior, individual and collective, by the traditions of the ages.

At the end of the text there is a complete list of references listed by chapter. As always, the bibliography will be of use and will be much appreciated by those interested in doing more work on this subject.

Because the book is limited in scope its use will probably be limited, too, but it should by all means have its place on the reference shelves in the private, public, and medical library.

BARBARA HURLEY,
Librarian, Denver Medical Library.

A.M.A. PREPARES TWO CIVIL DEFENSE BOOKLETS

What part the physician should play in civil defense activities is aptly depicted in a series of six articles which A.M.A.'s Council on National Emergency Medical Service currently is offering in booklet form. Reprinted from the Journal of the A.M.A., these articles discuss such aspects as organizing for civil defense, developing medical participation in civil defense, the physician's civil defense responsibilities, and the doctor and the improvised hospital.

In addition, the Council now has available the "Proceedings of the Medical Civil Defense Conference" which was held in February in Louisville, Kentucky. This should prove a valuable sourcebook inasmuch as it contains rather thorough discussions of atomic bombing, the threat of biological warfare, civil defense against chemical warfare, psychological warfare, and a case study of a typical state's civil defense organization.

Both booklets may be secured on request from the Council.

FINDINGS OF FIRST YEAR'S STUDY OF DOCTORS IN SERVICE

Results of the first year's survey of physicians leaving active military service are carried in a report recently issued by the A.M.A.'s Council on National Emergency Medical Service. Information obtained from this continuing questionnaire study is being used as the basis for a series of conferences with Department of Defense and Armed Forces representatives in an effort to improve the utilization of medical personnel and the formulation of a more effective voluntary officer procurement system.

During the first year of the study—July 15, 1952, to August 1, 1953—a total of 3,948 completed questionnaires revealed that the average time spent in service was 24.7 months; average tour of duty in U. S., 7.6 months; average tour of foreign duty, 17.1 months. Twenty-nine per cent felt there was overstaffing, 20 per cent understaffing and 51 per cent adequate. Of those assigned to domestic duty, 53.4 per cent were engaged in treating military personnel, 28.3 per cent in treating military dependents and 18.3 per cent in "other;" while of those assigned to overseas duty, 51.8 per cent treated military personnel, 23.8 per cent dependents of military personnel and 24.4 per cent "other." Answers to the question regarding the type of medical care provided for other than military personnel indicate that in the Army and Navy the most frequent type was outpatient care, while in the Air Force it was obstetrics and gynecology.

Regarding the question, how national and local medical associations can better serve their members in service, the following activities were suggested—more information via a newsletter, etc.; personal visits by civilian doctors to evaluate grievances; invite military doctors to civilian medical meetings; assist in locating position after discharge; assist in preventing evasion of military service; distribution of questionnaires to physicians in service; provide specialists for clinical conferences.

STOP THOSE HIGHWAY KILLERS!

Tragedy on the highway caused by Highway Killer Number Three—the drinking driver—is aptly depicted in a new exhibit now being offered to local medical societies by the A.M.A.'s Bureau of Exhibits. "Alcohol Tests for Drinking Drivers" points up the fact that the drinking driver ranks third in traffic violations resulting in fatal accidents and is led only by violations of excessive speed and failure to keep on the right side of the road. Advantages and disadvantages of different methods of testing the drinking driver are visually demonstrated in this attractive exhibit, and a series of simulated windshields show the progressive changes in the drinking driver's vision through the four stages —sober, fuzzy, dizzy and drunk.

Prepared by the A.M.A. in cooperation with the Committee on Chemical Tests for Intoxication of the National Safety Council, this exhibit also shows that drinking pedestrians account for one out of four pedestrian deaths. This exhibit is now available on a loan basis.

IN VIEWING THE VA MEDICAL PROGRAM . . .

what we are talking about...

1. Lack of moral or legal justification in providing federal medical care for ALL veterans
2. Effect of the VA program on civilian medical training programs
3. Current and eventual effects of VA program on civilian health standards
4. Competition for health personnel and patients
5. Unsound economics of overlapping federal medical services
6. Expanding tax-burden
7. Veterans' attitude toward VA medical program

These seven points are the conclusions of a careful analysis by the medical profession of the current VA medical program. (1) Veterans with no service-incurred disability should assume responsibility for their own medical care on the same basis as other citizens. (2) Medical schools and hospitals are hard pressed to train enough medical personnel for the benefit of all as long as the federal government siphons off such personnel from civilian programs. This VA practice has caused a duplication of hospital facilities and an unwarranted dispersion of health personnel. (3) The VA is creating an "artificial" shortage of medical personnel at the expense of civilian health programs. (4) Government has placed itself in competition with civilian medical programs, both for personnel and patients, making it increasingly difficult to operate civilian hospitals efficiently and economically. (5) Although the federal government is spending millions of dollars under the Hill-Burton act in civilian hospital construction, these hospitals are hard pressed to operate at reasonable cost while in direct competition with hospitals **wholly** supported by the federal government. (6) The medical profession asks whether a program providing "free" medical care to veterans with no service-incurred disabilities is a justified burden to impose on the taxpayers of this country. (7) Physicians do not believe that a veteran who served his country wishes to be the recipient of a federal "handout" at the expense of his fellow citizen-taxpayers.

HEALTH EDUCATION ON THE RADIO

Running the gamut from A to Z is the current list of available electrical transcriptions from the A.M.A. Bureau of Health Education. Thirty-three different series—all but one of which consists of thirteen programs—now are being circulated around the country. These fifteen-minute complete programs cover practically every phase of medicine from the "Story of Surgery" to "Hi-Forum," a discussion program involving high school students and their health problems.

The most popular program, as reflected by radio stations throughout the country, is "Heart of America"—of which 34 different sets now are in circulation. Next most popular is the dramatized series, "Why Do You Worry," of which 20 sets now are being used. Other widely-circulated programs include—"Medicine Fights the Killers," "Interlude," "Chats With the Champs," "Before the Doctor Comes," and "Train Up a Child."

All of these programs are available to local medical societies or health agencies with the approval of the local society. In addition, radio transcriptions also are being distributed on a state-wide basis by ten medical societies. Any state medical society can be designated as a distributing agency if it so desires by contacting the Bureau.

NEW SERIES OF "WHAT TO DO" FILMS FOR TV

What to do? . . . When dad cuts his finger . . . or sister has a sore throat . . . or brother won't eat his vegetables . . . to help mother come up with the right answers to these common household problems are six new five-minute films telling "What to Do" when these emergencies arise. Produced especially for television in local communities by the American Medical Association, this new dramatic series tells in simple language what to do before the doctor comes and when and how to apply first aid. Subjects include: sore throat; contagious diseases in the home; good eating habits; home accidents; convalescent child, and cuts and bruises.

Featured in these films is Miss Abby Lewis, wel-known Broadway-radio-TV character actress. Direction is by Martin Magner and general supervision by W. W. Bauer, M.D., director of A.M.A.'s Bureau of Health Education.

These films are available on loan to local medical societies or to other health agencies with the approval of the local medical society. Inquiries should be directed to the A.M.A. Film Library, 535 North Dearborn, Chicago 10.

MEDICAL PROBLEMS AIRED AT LEGISLATIVE MEETINGS

Regional legislative conferences were conducted in January and February by the A.M.A. Committee on Legislation in San Francisco, Denver, Dallas, Atlanta, Chicago and New York. Purpose of these meetings was to discuss ways of improving the committee's system of alerting key legislative personnel on situations requiring immediate contacts with members of Congress and to air the most important medical issues which will be considered during the second session of the 83rd Congress.

Results of the questionnaires distributed at each of these meetings reflect the general thinking of the profession regarding some of the key medical issues. Of the 328 persons who attended these conferences, 229 returned the questionnaire. Regarding the extension of social security to physicians, 45 were in favor and 176 were opposed; on the Bricker amendment—172 in favor, 46 opposed; on the A.M.A. position regarding veterans medical care for non-service-connected disabilities—192 in favor, 35 opposed.

Principal topics discussed at these meetings were: federal subsidization of private health insurance plans; extension of social security coverage to include physicians; tax deferments on premiums used to purchase retirement annuities; proposed amendment to limit treaty making powers (introduced by Sen. Bricker); medical benefits for veterans with non-service-connected disabilities.

WANTADS

FOR SALE: Two metal examining tables in good condition. $125.00 each. Drs. Ley and Thurston, 517 Colorado Avenue, Pueblo, Colorado.

WANTED: Used x-ray and necessary related equipment, preferably 100 ma; used fcc approved diathermy. Contact E. J. Shidler, M.D., Brighton 770-W.

TWO DOCTORS considering taking in third man. Located Montana's best hunting and fishing area. If interested in such location write for arrangements to stop and look when traveling this summer. Contact Box 7, Rocky Mountain Medical Journal.

NEW ACCOMMODATIONS for two doctors. Three-room office suites each, plus reception and lab. Plenty parking. Ground floor. 4500 block South Broadway. Reasonable rent or will sell. SU. 1-2085.

OBSTETRICIAN-GYNECOLOGIST, aged 30, University hospital training, Board eligible, two years' practice in specialty, category IV, excellent references, desires office space or location with another obstetrician or established group. Available May, 1955. Contact Bax 7A, c/o Rocky Mountain Medical Journal.

RELIABLE DRUGGISTS

PATRONIZE DENVER'S INDEPENDENT DRUGGISTS

25 Years in the Heart of North Denver

LUBIN'S DRUG

LUBIN L. ORTIS, Owner

PRESCRIPTIONS ACCURATELY COMPOUNDED

Free Delivery Service

West 38th Ave. and Clay Denver, Colo.

Phone GLendale 5-1073

Kincaids Pharmacy

BE 3-4621

7034 W. COLFAX

Quality Drugs *Courteous Service*

Adjustable Crutches for Rent
Surgical Supplies
Drugs and Prescriptions

FREE DELIVERY IN LAKEWOOD AND METROPOLITAN DENVER

WE RECOMMEND

Whittaker's Pharmacy

"The Friendly Store"

PRESCRIPTION SPECIALISTS

West 32nd and Perry, Denver Colo.

Phone GLendale 5-2401

HYDE PHARMACY

ACCURATE PRESCRIPTIONS

Chas. W. Hyde, *Prop.*

Rocky Mountain Distributors for Sherman Biologicals and Pharmaceuticals
Almay Non Allergic Cosmetics

Prompt Free Delivery

KE. 4-4811 MA. 3-4566

1400 East 18th Avenue at Humboldt

DENVER, COLO.

— NOW —

A Professional Store with 24-hour Service

We are open 9 A.M. to midnight.
We are ALWAYS available by phone and we are happy to serve you and your patient at ANY HOUR.

IMMEDIATE, FREE Delivery Day or Night

Our delivery service covers Colorado Blvd. east to KOA tower, bounded by 6th Ave. and 38th Ave. In cases of emergency we will deliver anywhere free of charge.

Phone EM. 6-1531 (24-hour service)
Should there be no answer, dial DE. 3-4909

LK Professional Pharmacy

9350 E. Colfax Ave.

DRIVE-UP SERVICE WINDOW

EARNEST DRUG

217 16th Street

Prescription Specialists

Telephones KEystone 4-7237—KEystone 4-3265

FRESH — CLEAN — COMPLETE

PRESCRIPTION STOCK

Free Delivery

Bonita Pharmacy

(Established 1921)

Prescription Pharmacists

6th Avenue at St. Paul Street

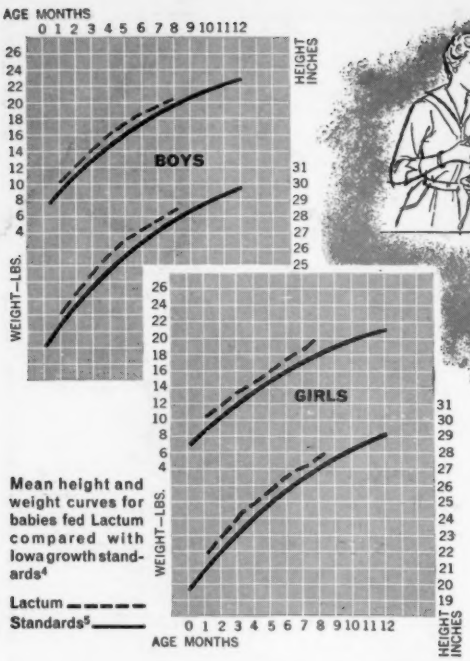
"RIGHT-A-WAY" SERVICE

GERALD P. MOORE, ***Manager***

Phone FRemont 7-2797

Patronize Your Advertisers

Index to Advertisers



AMPLE PROTEIN FOR OPTIMAL GROWTH

Essential to the NEW BASIC CONCEPT in infant feeding

Accumulating clinical studies are convincing evidence of the infant's need for generous amounts of protein for optimal tissue and motor development.[1,2]

Lactum supplies 16% of its calories as protein, providing *an ample margin of safety* over the Recommended Daily Allowance for infants. A typical 24-hour Lactum feeding for a 10-pound infant provides 20 Gm. of protein—25% more than the National Research Council's Recommended Daily Allowance.* Babies fed Lactum® consistently show outstanding height-weight ratios (see charts).

The generous amounts of *natural milk protein* in Lactum contribute to an excellent level of satiety. Infants tend to have better dispositions and sleep well. Night feedings usually can be discontinued earlier.

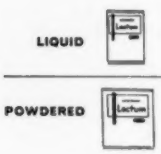
As an added safety factor, Lactum contains sufficient added carbohydrate (Dextri-Maltose®) to spare protein and permit efficient fat metabolism.[1,3]

The natural nutrients of the whole milk in Lactum are not manipulated in any manner. Nothing is substituted. All vitamins and minerals are retained in optimal amounts. And Lactum formulas supply *twice* as much vitamin B_6 as breast milk.

Lactum feedings are easy to prepare. One part of Liquid Lactum to 1 part of water, or 1 level measure of Powdered Lactum to 2 ounces of water, makes a formula supplying 20 calories per fluid ounce.

(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

Calculated on the basis of a daily allowance of 3.5 Gm. per Kg.



Lactum

nutritionally sound formula for infants

MEAD JOHNSON & COMPANY · EVANSVILLE, INDIANA, U.S.A. MEAD